



NCC Pediatrics Continuity Clinic Curriculum: Continuity Patient Case Day- *Overview*

Overall Goals & Objectives:

- According to the ACGME, the mission of the continuity experience is to help residents acquire competencies essential for **comprehensive, coordinated longitudinal care** of children with a wide variety of medical, behavioral, and social problems.
- Over 5 modules, residents will explore their on-going relationship with **1-2 selected continuity patients**, in order to learn how health conditions affect not only patients' physical well-being, but also their emotional and spiritual well-being, as well as that of their families.
- There are **two overall objectives** for each of these modules: first, to update your continuity group on the status of your selected patient(s); second, to reflect on your patient(s) in the context of a specific “doctoring” topic (*see Timeline*).

Overall Timeline:

** These are new modules for this academic year, so dates and topics are subject to change. Contact Dr. Hepps if you have ideas for alternate topics or feedback on current ones.*

<u>Dates</u>	<u>Topic</u>
Week Aug 20	Introduction & Dealing with Difficult Patients
<i>Week Oct 29</i>	<i>Cultural Competency & Healthcare Disparities</i>
Week Jan 21	Caregiver Fatigue & Work-Life Balance
Week Apr 15	Follow-up to Home, Therapy, School Visits
Week Jun 17	Medical Home & Continuity Patient Handoff



NCC Pediatrics Continuity Clinic Curriculum: Continuity Patient Case Day- Meeting 2

Pre-Meeting Preparation:

- *Update* the “Continuity Case Day Patient Profile” for the patient you selected in the last Case-Day module. *You may report on a different patient, if there are no updates on the one you previously shared with your group.*
- Review [“Combating Health Disparities . . .”](#) (AAP Nat’l Convention, 2012)
- Read “Cultural Competence in Clinician Communication” (PIR, 2009)
- Read Chapter 2 of “Culturally Effective Care Toolkit” (AAP, 2011)

Conference Agenda:

- *Review* EACH resident’s “Patient Profiles” for their selected patients.
- *Discuss* “Continuity Patient Case Day Discussion Prompts”.

Post-conference Activity:

- Take [“The Provider’s Guide to Quality & Culture Quiz”](#) (<5min!)

Extra-Credit:

- [Community Pediatrics: Culturally Effective Pediatric Care](#) (AAP Section: incl. publications, Culturally Effective Care Toolkit, & Children’s Rights Curriculum)
- [CNMC Cultural Competence in Pediatrics Toolkit](#) (multiple link-outs)
- [“Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy”](#) (AAP Policy Statement, 2006)
- [“Culture and the patient-physician relationship”](#) (J of Pediatrics, 2000)



Continuity Case Day: Patient Profile

Select an interesting or challenging patient to follow longitudinally with your continuity group. Solicit feedback and guidance regarding your management or other challenges throughout the academic year.

1. Remind us, who is your patient? (Give a one-liner)
2. What are the issues you've been addressing? Any updates from last Case-Day?
3. What new questions do you have about your patient? Diagnoses? Treatment?
4. What are your plans for following-up with your patient?
5. Any other interesting patient encounters— aside from your selected longitudinal patient(s) — that you'd like to share with your group?

Cultural Competence in Clinician Communication

Cheryl Kodjo, MD, MPH*

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Objectives After completing this article, readers should be able to:

1. Define cultural competence.
2. Explain the need for cultural competence.
3. Describe the changing child demographics of the United States.
4. Discuss the process of becoming a more culturally competent clinician.
5. Review tools and techniques that help achieve cultural competence.

Note: A clarification has been posted.

Introduction

Some have suggested that cultural competence cannot be taught or learned and that some clinicians are just more sensitive than others when it comes to issues of cultural differences. Indeed, in some instances, we preach to the choir, if you will, regarding attitudes toward cultural competence. However, certain skills can be imparted to help all clinicians, regardless of their attitudes. As Dr Joseph Betancourt concludes, we would not accept substandard competence in other areas of clinical medicine, and cultural competence should not be an exception. (1)

Certain skills can be acquired, practiced, and honed on the journey of becoming a more culturally competent clinician. This article reviews the evolution and benefits of cultural competence in pediatric practice and gives examples of questions that can be asked to provide more comprehensive care to the patient and his or her family.

Cultural competence can be assessed via several methods. For example, evaluations or satisfaction surveys from patients, families, and staff, otherwise known as 360-degree evaluations, in a busy pediatric practice can provide useful feedback that prompts change in behavior. Observation, one of the best tools for evaluating clinician behavior, can be performed by using either standardized or real patients. Observed role-playing with standardized patients can provide clinicians with formative feedback to improve their interviewing skills. Observation of interactions with actual patients or unidentified standardized patients, similar to the observation model used in education, captures actual clinician behavior when functioning under pressure.

The Landscape

The Institute of Medicine issued its landmark report about health disparities in 2002, referencing inequities in adult health-care services. Pediatrics is a part of the health disparities landscape, with many health outcomes being complicated by childhood poverty. Classic examples of pediatric health disparities include differences in immunization status, care of asthma, and prevalence of teen pregnancy. Although the terms “health disparities” and “cultural competence” often are used interchangeably, cultural competence is one vehicle, along with increased access, insurance coverage, and others, that can improve health outcomes through improved communication and increased trust and understanding between patient and clinician.

What is Cultural Competence?

Culture is defined as patterns of human behavior inherent in the lives of a racial, ethnic, religious, or social group. Some social groups can be defined by age, generation, ability, body image, and mental illness, for example. Characteristic behaviors can include

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thoughts, language, customs, beliefs, and institutions. For example, adolescents are their own culture (subculture), characterized by how they communicate, how they wear their clothes, the types of music to which they listen, and what they value.

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

Cultural competence, therefore, is an acknowledgment and incorporation of the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs on the part of clinicians and health-care systems. Some clinicians state that they interact with all patients in the same manner. Indeed, being culturally competent implies that clinicians not treat patients the same, given the cultural dynamics each brings to the encounter.

Cultural competence is a concept that has come to medicine slowly, although it has been discussed in the nursing and psychology literature extensively. Cultural competence terminologies have evolved over the past 2 decades from cultural awareness to cultural sensitivity to cultural competence. Other terms, such as cultural effectiveness and cultural humility, are used currently. Regardless of the term used, the principles of cultural competence may be recognized most often when they are absent. These principles include empathy, curiosity, and respect, with which comes a heightened understanding and appreciation of the social context of the patient.

The term cultural competence is used in this article because it is a familiar term to most clinicians, although it falsely implies that some endpoint can be reached. The exact opposite is true, however; no one ever becomes “competent.” Cultural competence is a process, built upon by asking questions of the patient, family, and oneself.

Why is Cultural Competence Timely and Crucial?

Clinicians today are practicing in the midst of a rapid change in the demographics of the pediatric population of the United States. New York is one of several states that has stood apart in terms of patterns of immigration over the past century. The immigrant child population is the fastest growing portion of the child population. In contrast to the white European and English-speaking

immigrant populations that migrated to the United States in the early 20th century, families from the Caribbean, Africa, and Asia constitute significant immigrant groups today.

Noteworthy is the growing Hispanic population. Immigrants from Mexico and Central America who are settling and raising their families in the United States, similar to other immigrants, are looking for greater economic opportunities or seeking safety from the conflict of war. It is estimated that by the year 2020, Hispanic adolescents will constitute the largest minority youth population and that approximately 40% of all youth will belong to a minority group.

Given the change in the cultural makeup of the United States, clinicians are being challenged as never before to provide cross-cultural care that is sensitive, effective, and able to meet the needs of the patient and family. Cross-cultural care requires that clinicians be open and seek to understand the various dynamics of the patient-clinician encounter, such as variations in the perception of illness, diverse belief systems around health, differences in help-seeking behaviors, and preferences in approaches to health care. Therefore, cultural competence is not a question of “doing the right thing.” Rather, it is an important vehicle for achieving patient satisfaction, patient safety, and improved health outcomes.

The Cultural Divide

One of the first challenges in achieving culturally competent practice is acknowledgment that medicine is its own culture, often at odds with the cultural orientation of patients. Western medicine puts a high priority on concepts such as individualism, emphasizing that the individual has control over his or her health. Western medicine also endorses the following: diseases have specific causes, there is one system of care to address the disease, and patients adapt to the system. Pediatric clinicians may have particular assumptions about family dynamics and how families mobilize on behalf of their children to make health-care decisions.

In contrast to the culture of Western medicine, patients' cultural norms may demonstrate more community than individual orientation, conceptualize circumstances as being beyond their control, see disease as a result of misfortune or imbalance, and use other treatments in combination with or to the exclusion of Western medicine. To bridge this gap, the onus is on the clinician to ask questions that uncover such orientations to health and illness so they can be integrated into the

caretaking of the patient and family and negotiated, if possible, when making health-care decisions.

What Does It Take to be a Culturally Competent Clinician?

As mentioned, cultural competence involves empathy, curiosity, and respect. Although being aware of the history, health beliefs, and practices of a particular cultural group can provide a foundation for understanding, such knowledge must be balanced carefully to avoid stereotyping and to accommodate diversity within groups. Resources such as *Working with an Interpreter: Stronger Outcomes Tips* at www2.massgeneral.org/interpreters/working.asp and additional sites (listed at the end of the article) cover general information regarding various racial and ethnic groups. In addition to these broad guidelines, there is an important role for asking questions to acknowledge and create deeper understanding of how the many layers of culture interact within the individual patient and family to influence health care.

Before beginning the process of engaging with the patient, clinicians must have an idea of their own sensibilities, an awareness that comes with self-reflection. Five key goals should be sought in this process of becoming culturally competent:

- The first is the capacity for being self-aware. In other words, are we aware and mindful of our own cultural beliefs, values, and behaviors? How do these factors affect our interactions with patients? If we cannot manage our biases for the sake of the patient, do we recognize that limitation and defer to a colleague? A classic example is counseling about reproductive health choices, including abortion. If such counseling is not congruent with a clinician's beliefs, he or she should help direct the patient to someone who can do such counseling.
- The second goal is being aware and accepting of cultural differences. This mindset is self-explanatory and implies developing a value for diversity.
- The third goal is understanding the dynamics of difference. This is particularly important for physicians, given the power bestowed on them by titles, white coats, and other attributes. If we believe in a particular treatment for a patient and the patient does not agree, based on cultural difference, because of our sense of power, we may not respect and work with that difference.
- The fourth goal is assessing our own cultural knowledge. Such knowledge is shaped by interacting and integrating lessons learned from colleagues and pa-

tients with whom we interact. We also should be aware of our limits and know when to ask for help with particular populations with whom we may be less familiar to determine core principles for a particular culture.

- Finally, a culturally competent clinician must be able to adapt to diversity. How do we adapt to the needs and preferences of our patients? Are we open to different approaches to the same problem?

The Surprises and Challenges of Cross-Cultural Communication

Cultural competence is not only an orientation to employ when the patient speaks a different language or looks different from the clinician; it should be engaged with *every* patient. Some of the most surprising instances of cultural “disconnects” occur with patients and families who look like their clinicians. Regardless of shared race, ethnicity, or cultural identification, we may not have the same values, perspectives, or choices as our patients.

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

What are the Key Questions We Need to Ask?

Exploring the Meaning of Illness

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

A 17-year-old African American girl comes in for a scheduled health supervision visit. While performing a psychosocial assessment, you note that she appears agitated. After some time, she states that she wants oral contraceptives.

This is a case of asynchronous agendas. The patient's agenda was very well-defined, basically to avoid becom-

Table 1. Exploring the Meaning of Illness

Explanatory Model

- What do you think has caused your problem? What do you call it?
- Why do you think it started when it did?
- How does it affect your life?
- How severe is it? What worries you the most?
- What kind of treatment do you think would work?

The Patient's Agenda

- How can I be most helpful to you?
- What is most important for you?

Illness Behavior

- Have you seen anyone else about this problem besides a "physician"?
- Have you used nonmedical remedies or treatment for your problem?
- Who advises you about your health?

From material cited in Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med.* 1999;130:829–834. With permission.

*Note: Any clinician can be referenced here, that is, nurse practitioner, physician's assistant, nurse, etc.

ing pregnant. Asking questions that were more in the realm of a psychosocial history revealed that her two older sisters were adolescent parents and that she was eager to avoid the same outcome. She was seeking birth control at this visit and had specific ideas about what method she wanted and why. Questions to elicit the patient's agenda such as "How can I be most helpful to you?" at the beginning of the visit could have set the context for and increased the patient's satisfaction with the visit.

A 15-year-old white girl and her mother come in for consultation regarding general body aches and sleep disturbance. The patient has seen various specialists, and results of evaluations have been benign. The mother has consulted family members, friends, and neighbors regarding what could be wrong with her daughter. In particular, the girl's aunt seems to have had substantial input regarding potential causes and nonmedical treatments for the girl's problems.

The clinician in this case had to negotiate with more people than actually were present in the room at the time of the visit. Being respectful and listening to the ideas of the family were important to establishing rapport with this family. Questions such as "Have you used nonmedical remedies or treatment for your problem?" can help

open the door to a comprehensive conversation about how patients help themselves.

Such an approach also gave the clinician a sense of the family's interest in complementary and alternative medicines, demonstrated the clinician's openness to such considerations, and allowed the clinician to steer them toward appropriate alternative treatments. Some of the therapies that were proposed and accepted by the family included melatonin/valerian root for sleep disturbance, peppermint for stomach upset, and yoga for general conditioning. Also, continued biofeedback therapy, in which the family already was engaged, was encouraged. Asking about and coordinating care with complementary and alternative medicine clinicians or traditional healers in the community can be validating to a family and encourage a nonmutually exclusive approach to a health condition.

A Chinese father brings in his 9-month-old son for a health supervision visit. The baby has been doing well, but the baby's grandparents have been pressuring the father to start feeding the child eggs. The clinician summarily tells the father that eggs are not recommended until 12 months of age because of the risk of food allergies. She suggests that the father use her as the scapegoat with the grandparents for adhering to this recommendation.

This case encompasses the issue of who advises parents about their child's health. Although pediatric clinicians see themselves as the pillars of prevention and health, many other influences affect the daily lives of children, such as grandparents. In this case, the clinician missed an opportunity to inquire about the cultural importance of eggs to this Chinese family's diet. Questions such as "Tell me why this is important to you and your family" open a dialogue to increase understanding of a family's explanatory model for health. Instead, this clinician closed the conversation with no guarantee that the father is in agreement with the recommendation or that the father will disclose the family's health beliefs in the future.

Social Context "Review of Systems"

The social context of patients can affect their health and presentations. Poverty is one of the most significant barriers to health and access to health care. Table 2 highlights questions regarding resources, change in environment, social supports, and literacy, which can open the dialogue. Understanding of such social factors can increase the clinician's appreciation of the challenges encountered by patients and compensate for them in counseling and treatment. The following four actual patient cases demonstrate this focus.

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

The clinician in this case was able to determine that finances were an issue for this family and would affect the family's ability to purchase medication. In light of this situation, frank discussion of how much the family could afford was possible. The mother agreed to the idea of purchasing the medication for 2 weeks until she met her next pay period. The ability to consult social workers or

community health workers who can perform outreach to a family can increase access to services as well as increase understanding of the challenges families may face.

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

As is common for many immigrant children, this patient was between two worlds. She was mourning the loss of the life she had in Jamaica while being confronted daily with the unpredictability of her family life in a new country. Her mother had to work jobs that paid "under the table," which sometimes meant that her mother needed to move away for months at a time, leaving the patient with other family members. Questions such as "Tell me what brought you to this country" and "What was life like for you in your country?" elicit information about place and family of origin, changes in socioeconomic status, and acculturation. As in this case, just letting the patient/family tell their story can answer many critical questions.

A 19-year-old African American man is dealing with the second recurrence of his cancer. He is admitted to the hospital. Both parents are vigilant and at the bedside. Various family and church members come to pray for him. The number of visitors becomes more of an issue as the patient develops neutropenia and requires isolation.

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

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

Every patient has the right to be understood. This was

Table 2. Social Context "Review of Systems"

Control Over Environment

- Is money a big problem in your life? Are you ever short of food or clothing?
- How do you keep track of appointments? Are you more concerned about how your health affects you right now or how it might affect you in the future?

Change in Environment

- What is your country (city, town) of origin?
- What made you decide to come to this country (city, town)? When did you come?
- How have you found life here compared with life in your country (city, town)? What was medical care like there compared with here?

Social Stressors and Support Network

- What is causing the most difficulty or stress in your life? How do you deal with this?
- Do you have friends or relatives on whom you can call for help? Who are they? Do they live close to you?
- Are you very involved in a religious or social group? Do you feel that God (or a higher power) provides a strong source of support in your life?

Literacy and Language

- Do you have trouble reading your medication bottles or appointment slips?
- What language do you speak at home? Do you ever feel that you have difficulty communicating everything you want to say to the doctor or staff?

From material cited in Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med.* 1999;130:929–934. With permission.

a very awkward situation, in which the clinician did not speak much Spanish and, instead, was gesticulating and speaking loudly to make his points. The mother was concerned, and it was not clear by the end of the encounter that she understood the diagnosis, the treatments, or how the treatments were to be used. This situation creates the possibility for medical error. Knowing the language the patient speaks, preferably before the visit, allows for planning to have an interpreter present and develops a working scheme with the interpreter. The use of family members as interpreters should be avoided, despite being convenient. Family interpreters may not be able to interpret medical terminology and may hinder open communication knowingly or unknowingly.

This was a case of language being a barrier, but literacy can be a barrier in any language and should be considered when counseling and giving patient instructions. In those cases, use of diagrams and concrete language can help overcome the barrier.

Cross-Cultural Negotiation

Part of a clinician's responsibility during a patient encounter is negotiation of a treatment plan. This final case exemplifies differences in explanatory models for illness, the influence of family members, and the need to bridge the gap. Table 3 includes action steps to create shared understanding and agreement or, at the very least, an acknowledgment of clinicians' and families' boundaries.

A 5-year-old African American boy who has sickle cell disease is not taking his prophylactic medications. His mother thought the medications made him sick because once he stopped taking them, he had no further hospitalizations for his painful crises. When the clinician encourages the mother to reconsider her son's prophylactic medications, she hesitates to decide without the input of her own mother, the child's grandmother. A family meeting is arranged.

The mother's explanatory model was that the prophylactic medications used for sickle cell disease brought on the pain crises. Therefore, the family did not give the patient the medications to avoid this perceived consequence. Fortunately, the patient did not have pain crises during that period of being off the medication, which reinforced the explanatory model.

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

The family meeting gave the medical team a chance to

Table 3. Negotiation

Negotiating Explanatory Models

- Explore the patient's explanatory model.
- Determine how the explanatory model differs from the biomedical model and how strongly the patient adheres to it.
- Describe the biomedical model in understandable terms, using as much patient terminology and conceptualization as necessary.
- Determine the patient's degree of understanding and acceptance of the biomedical model as it is described.
- If conflict remains, re-evaluate core cultural issues and social context (eg, bring in family members or maximize interpretations).

Negotiating for Management Options

- Describe specific management options (tests, treatments, or procedures) in understandable terms.
- Prioritize management options.
- Determine patient priorities.
- Present a reasonable management plan.
- Determine the patient's level of acceptance of this plan (do not assume acceptance – inquire directly).
- If conflict remains, focus negotiation on higher priorities.

From material cited in Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med.* 1999;130:929–934. With permission.

re-explore with the family their conceptualization of how sickle cell disease works and to reorient these concepts within the biomedical framework. All family members present agreed to restart the prophylactic medications. The team would not have made progress with the non-adherence issues without involving the maternal grandmother very early in the negotiation process.

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

At the Systems Level

Cultural competence interventions also can exist at the systems level. Hiring practices of clinicians and office staff can demonstrate value for diversity. Physicians can support cultural competence training of office staff to enhance the quality of care provided at every point of the

patient encounter. Educational materials and posters on display can have diverse models and be in different languages. Techniques such as culturally competent health promotion, interpreter services, training, and accommodations such as allowing time and space for self-reflection by all staff can communicate a value for diversity within the practice or service.

Summary

Cultural competence is needed in pediatrics, especially in light of the ever-changing childhood demographics of the United States. Becoming a culturally competent clinician requires the fundamental attitudes of empathy, curiosity, and respect that are constantly being reshaped by self-reflection. Clinicians can develop their skills in cultural competence by incorporating questions about the meaning of illness, performing a “review of systems” within a social context, and negotiating explanatory models and treatments into their interviews with all patients. Diversifying staff and ensuring that the office environment and protocols are inclusive and respectful of other cultures can solidify a commitment to culturally competent practice.

Reference

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Suggested Reading

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Web Sites

- Culture Clues™ at: <http://depts.washington.edu/pfes/cultureclues.html>
- CulturedMed at: <http://culturedmed.sunyit.edu/>
- DiversityRx at: www.diversityrx.org/
- The Manager’s Electronic Resource Center at: <http://ethnomed.org/>
- National Center for Cultural Competence at: <http://www11.georgetown.edu/research/gucchd/nccc/>
- Resources for Medical Education on the Provision of Culturally Effective Care at: http://www.aap.org/visit/CEPC_resources_COPE_7-16-08.xls
- United States Department of Health and Human Services. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Final Report, March 2001 at: <http://www.nhmad.org/pdf/CLASfinalreport.pdf>
- Working with an Interpreter: Stronger Outcomes Tips at: www2.massgeneral.org/interpreters/working.asp

Evaluation Tools

- Cultural Competence Health Practitioner Assessment at <http://www11.georgetown.edu/research/gucchd/nccc/resources/index.html>
- Cultural-Competency Organizational Assessment – 360 (COA 360) at <http://apps22.jhsph.edu/coa360/>

Culturally Effective Care Toolkit

(Entire Toolkit found [HERE](#))

Introduction

The care that pediatricians provide to an increasingly diverse child and adolescent population should encompass medical home principles; it should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The American Academy of Pediatrics (AAP) defines *culturally effective care* as “the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions leading to optimal health outcomes.” Such understanding should take into account the beliefs, values, actions, customs, and unique health care needs of distinct population groups.

This **Culturally Effective Care Toolkit** is a practical, hands-on resource to help practicing pediatricians and their office staff provide culturally effective care to their patients and families.

- Chapter 1: What Is Culturally Effective Pediatric Care?
- Chapter 2: Health Beliefs and Practices
- Chapter 3: Nutrition, Feeding, and Body Image Perspectives
- Chapter 4: Behavior and Child Development
- Chapter 5: Interpretive Services
- Chapter 6: Literacy and Health Literacy
- Chapter 7: Medical Education
- Chapter 8: Tips, Tools, and Resources for Implementation
- Chapter 9: Continuing Medical Education Opportunities

Chapter 2: Health Beliefs and Practices

Many variables such as culture, socioeconomic factors, generational practices, and current trends affect patients’ and families’ health beliefs and practices. Routine and accepted US health care system processes, structures, and norms may be unfamiliar to patients and families from other countries or cultures. Following are some of the areas in which pediatricians are most likely to encounter differing (or a range of) perspectives.

Clinic and Emergency Department Use

Pediatricians understandably expect patients to comply with a predictable and scheduled appointment format. However, patients from other countries or cultures may be accustomed to different processes. In certain countries in Latin America, for example, patients are expected to walk in to a clinic or practice, take a number, and wait for the provider, instead of being scheduled for a specific time. Likewise, patients may favor using emergency services for non-emergent complaints rather than accessing a primary care provider. Some patients may use the emergency department as a medical home because of perceived advantages in accessibility, availability of ancillary laboratory and radiology services, and even availability of interpretive services. Pediatricians should clarify the scheduling process in their practices.

Pain and Analgesia

The expression of pain and the health-seeking behavior centered on the relief of pain varies from culture to culture. For example, in some cultures it is considered honorable and desirable to stoically tolerate pain, while these same behavior expectations are not shared by other cultures. While there are culturally associated variations in patients’ expression of pain, physicians’ analgesic prescribing responses to patients of different cultures also may vary. Although some research studies have demonstrated that physicians may prescribe less analgesia to ethnic and racial minority populations, there is evidence to suggest that the disparity has lessened over time.¹

Traditional Practices, Alternative Medicine, and Indigenous Healers

It is increasingly recognized that some patients from the United States or other countries use alternative or traditional practices, medicines, or healers. Families may use these options prior to, in combination with, or after seeking medical care from the pediatrician. In some cultures, the concept of a “folk illness” is embraced and there is a strong belief in a definite constellation of symptoms and treatments associated with the folk illness. Pediatricians should respect patients’ health beliefs that may not be consistent with a biomedical model of disease etiology. For example, some Latino/Hispanic families believe in folk illnesses such as empacho (gastrointestinal discomfort), susto (a form of panic attack), or mal de ojo (evil eye). Many traditional practices used to treat these and other folk illnesses may be entirely benign, while others have been associated with adverse health outcomes. Folk medicines such as greta and azarcon, often used by Mexican Americans, may contain elevated lead levels and have been associated with lead poisoning in children.

Bed Sharing and Sudden Infant Death Syndrome

Since the American Academy of Pediatrics (AAP) [Back to Sleep campaign](#) to decrease the incidence of sudden infant death syndrome (SIDS), there has been a substantial increase in the percentage of mothers that place their babies to sleep on their back or sides. However, in some minority populations, this public health campaign has not been as effective. African American mothers, for example, are more likely to share beds with their infants and place them in a prone position to sleep, both risk factors for SIDS. Co-sleeping is considered a culturally acceptable, if not desirable practice in some communities. Also, in large families with few resources, co-sleeping can be viewed as a necessity rather than an option.

Birth and Early Infancy

At birth and immediately after birth, different cultural groups may have specific norms regarding the amount of postpartum time mothers are to remain indoors, the care of the umbilicus, early feedings, co-sleeping, circumcision, and others. In some cultures, for examples, mothers and newborns stay secluded indoors for a defined period. In other cultures, because of limited resources or cultural practices, newborns sleep in the same bed with their mother. Another example of a culturally bound practice involving newborns and babies centers on covering their heads, even if in tropical climates.

Death and Dying

Death rituals are often shaped by culture. In dying or severely ill patients, the amount of information that physicians and families share with the patient about his or her prognosis, the patient and family members’ expression of grief, the use and acceptance of hospice care, the termination of life support systems, the integrity of the body and burial, and other end-of-life issues pose significant cross-cultural and bioethical challenges for pediatricians. Koenig and Gates-Williams² offer the following helpful guidelines in dealing with these complex situations:

- Determine who controls access to the body and how the body should be approached after death.
- Consider the relevance of religious beliefs, particularly about the meaning of death, the existence of an afterlife, and belief in miracles.
- Assess how hope for a recovery is negotiated within the family and with health care professionals.
- Assess the degree of fatalism versus an active desire for the control of events into the future.

Role of Women

The culture-specific roles of women and men have the potential to affect the care of pediatric and adolescent patients. In some cultures, for example, women are expected to defer important decisions to and, in some instances, to communicate through the male figure. The concept of machismo in Hispanic cultures often portrays the masculine figure as a protector, provider, and decision-maker. Whereas the cultural connotation may be one of masculine honor and respect, it can be viewed as disempowering toward women. Men in some cultures, for example, may exert power and control over women. If men are viewed as final decision-makers on health matters, this may affect pediatricians' ability to empower female adolescent patients. This culturally bound and potentially disempowering role of women can adversely affect their ability to successfully negotiate condom use with a male sexual partner.

Role of Family

Given the cultural variability of the role of the patient's family in medical decision-making as well as healing processes, the pediatrician should respectfully ask questions with the goal of fully understanding these important issues. In some cultures, the family (nuclear and extended) is the main social unit and family members are actively engaged in all aspects of the care of the patient. In dealing with hospitalized patients, for example, pediatricians should anticipate the possibility of a large number of family members during visiting hours and the possibility of exceeding the hospital's allowable visitors' quota. Immigrant families may be divided between the United States and the country of origin, posing an added stressor in family-centered cultures.

Chapter 2 Tool and Resources

Tool 2A: [AAP Healthy Child Care America: Back to Sleep Campaign](#)

This Web site includes free, downloadable patient information materials in English and Spanish.

Resource 2A: Management Sciences for Health: [The Provider's Guide to Quality & Culture: Relating to Patient's Families](#); *This Web site provides additional tips and helpful resources to relate and interact with patients' families.*

Resource 2B: Book chapter: ["Analgesia"](#) (Use "Skim This Chapter" to move to page 64.)

Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Smedley BD, Stith AY, Nelson AR, eds. Washington, DC: National Academies Press; 2003:64–66

This section of an Institute of Medicine publication provides summary of research studies on analgesia in minority populations.

Resource 2C: National Women's Health Information Center, US Department of Health and Human Services Office on Women's Health: [Health Professions: Your Role in Women's Medicine: Ethnomedicine](#)

This Web site provides links to additional information and resources about traditional practices, alternative medicines, and indigenous healing.

Resource 2D: ["Sleep Arrangements and Behavior of Bed-Sharing Families in the Home Setting"](#)

Baddock SA, Galland BC, Taylor BJ, Bolton DP. *Pediatrics*. 2007;119:e200–e207

Resource 2E: [Transcultural Aspects of Perinatal Health Care: A Resources Guide](#)

American Academy of Pediatrics. Shah MA, ed. Elk Grove Village, IL: American Academy of Pediatrics; 2003
Chapters cover health and illness, pregnancy and prenatal care, labor and delivery, postpartum and newborn care, and more.

Resource 2F: [Culture & Clinical Care](#)

Lipson JG, Dibble SL, eds. San Francisco, CA: UCSF Nursing Press; 2005

This book provides information about cultural and ethnic-specific practices, beliefs, and norms, including birth and death rituals and the care of newborns and mothers.

Continuity Case Day: Discussion Prompts

1. How does the PIR article define cultural competence? Would you adjust this definition at all to account for the military sub-culture? Do health disparities exist under Tricare?
2. What are some examples of the “cultural divide” you have seen in your daily practice? (*HINT: Chapter 2 of the Toolkit lists some examples*)
3. According to the PIR article, what are the 5 goals to becoming a culturally-competent clinician? Discuss how you can apply these to your own practice.
4. What does it mean to “[explore] the meaning of illness”? How have you applied or how can you apply this to your own practice? Think of some examples.
5. What elements does the PIR article suggest you include in the “social context ‘review of systems’”? Do you ask any of these questions already? Are there additional questions you would add for our military population?
6. What does it mean to engage in “cross-cultural negotiation”? Select one of the differences in Health Beliefs & Practices from the Toolkit and role-play the negotiation.