

# Improving Health Quality Through Effective Cross-Cultural Communications

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## Learning Objectives:

1. Describe important differences in communication (relationship-centered care) that exist among patients from diverse backgrounds who have different world views.
2. Identify the major communication differences between physicians and patients who are ethnically concordant versus discordant.
3. Identify key clinical, educational, and health system strategies for improving relationship -centered care between patients and providers from diverse backgrounds.
4. Describe ways that stereotyping can affect health outcomes
5. List strategies to uncover stereotyping and improve health outcomes

# A major component of diversity and inclusion training is ...

Taking the Implicit  
Association Test **A**

Keeping personal  
reflections in a journal **B**

Expressing sympathy  
for targeted groups **C**

Awareness **D**

# Cross-cultural communication

Cross-cultural communication is a field of study that looks at how people from differing cultural backgrounds communicate, in similar and different ways among themselves, and how they endeavor to communicate across cultures.



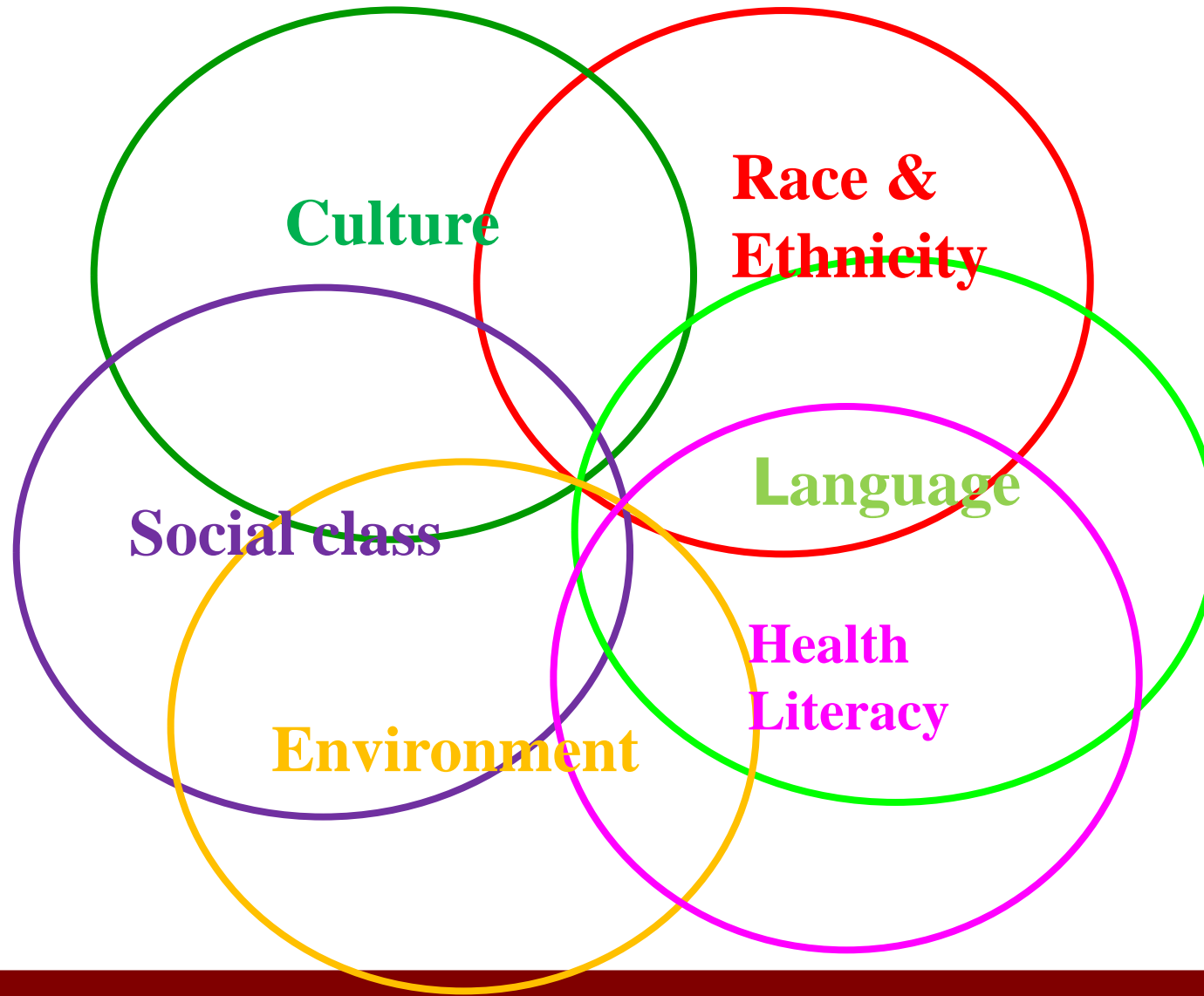


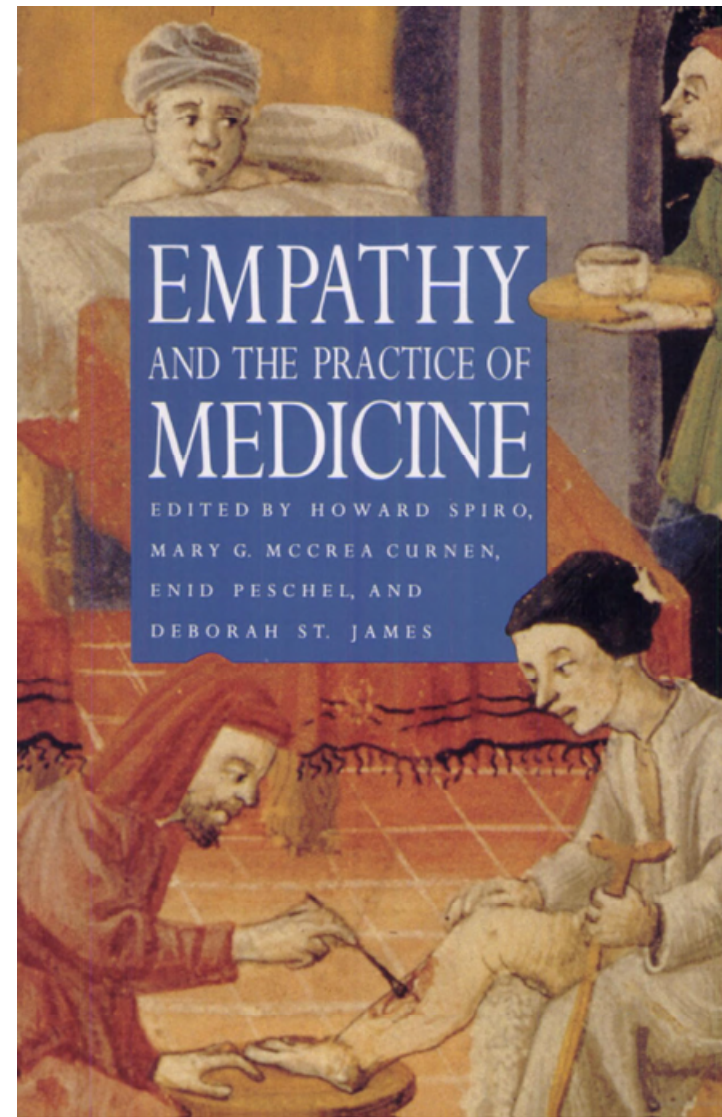
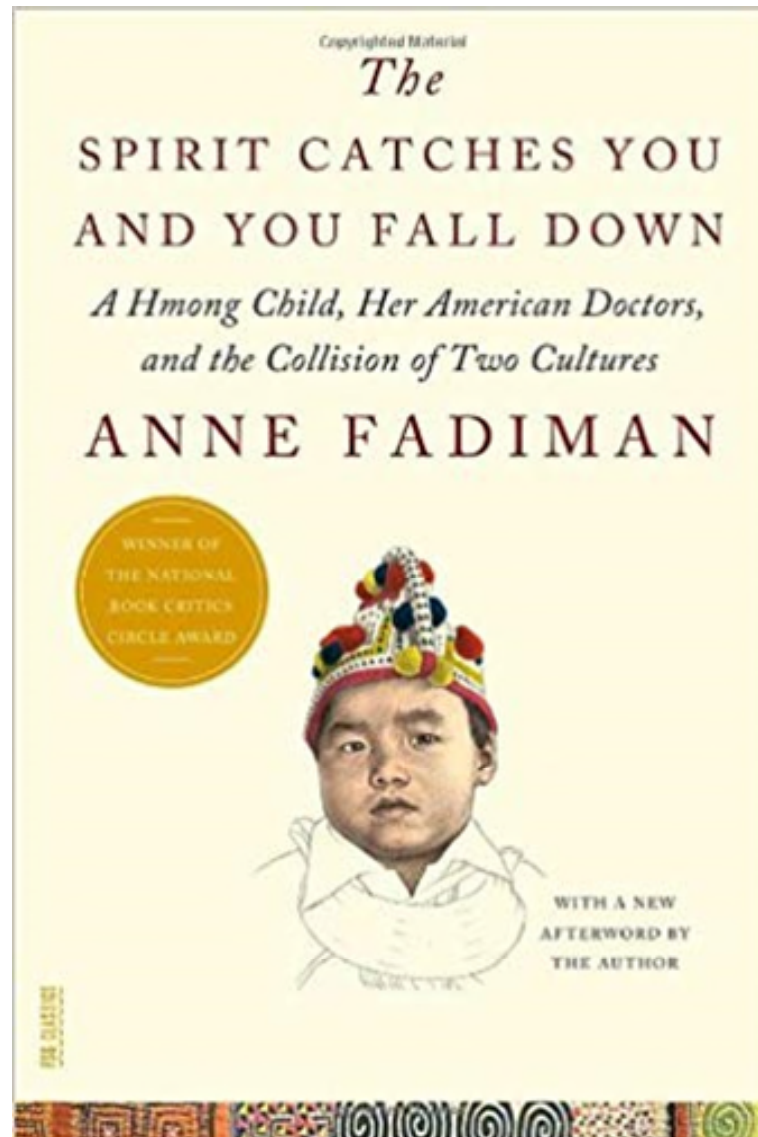
# Sources of Miscommunication in Cross Cultural Exchanges

- 1) **Assumption of similarities** : This refers to our tendency to think how we behave and act is the universally accepted rule of behavior.
- 2) **Language Differences** : Problems occur when there is an inability to understand what the other is saying because different languages are being spoken.
- 3) **Nonverbal Misinterpretation** : The way we dress, the way we express ourselves through our body language, eye contact and gestures also communicates something.
- 4) **Preconceptions and Stereotypes** : Stereotypes involves putting people into pre-defined slots based on our image of how we think they are or should be. It may consist of a set of characteristics that we assume that all members of a group share. A preconceived opinion of another can lead to bias and discrimination
- 5) **Tendency to evaluate** : Humans tend to make sense of the behavior and communication of others by analyzing them from one's own cultural point of view without taking into consideration why the other person is behaving or communicating a certain way
- 6) **High anxiety** : Sometimes being confronted with a different cultural perspective will create an anxious state in an individual who does not know how to act or behave and what is considered to be appropriate



# Factors Impacting Health Disparities





# Missouri Health 2018



Value indicates z score. Negative scores are below US value; positive scores are above US value.

Positive Impact

Negative Impact

- In the past three years, excessive drinking increased 23% from 16.1 to 19.8% of adults
- In the past five years, chlamydia increased 9% from 465.6 to 507.0 cases per 100,000 population
- In the past five years, low birthweight increased 10% from 7.9% to 8.7% of live births
- Since 1990, cancer deaths increased 5% from 198.2 to 207.2 deaths per 100,000 population

Source: America's Health Rankings: Missouri 2018.

<https://www.americashealthrankings.org/explore/annual/state/MO>

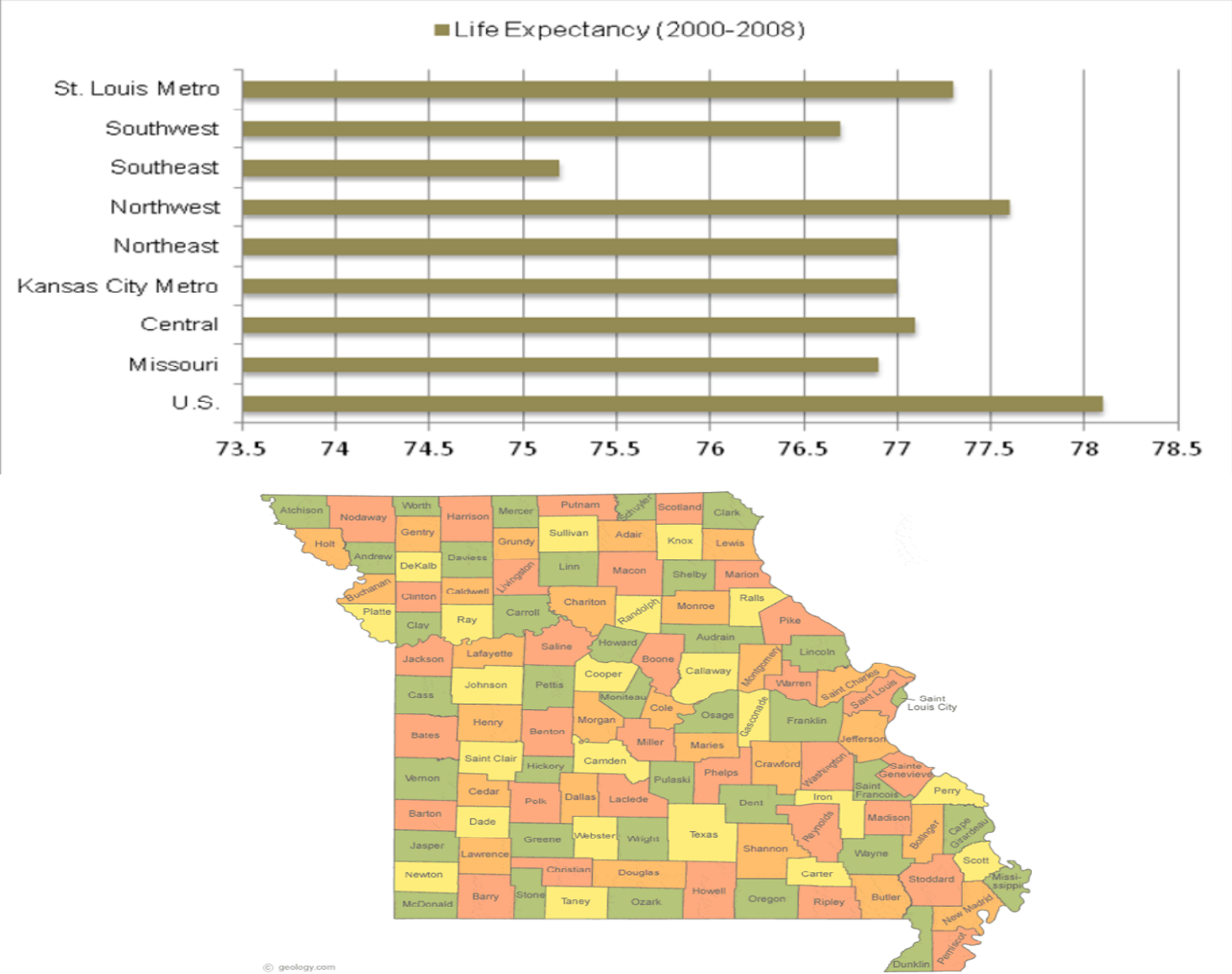
# Missouri Health Challenges

- One of the lowest per-capita spending rates for public health funding in the country
- Lowest in the country tobacco taxes that, if raised, could significantly reduce smoking rates and generate needed state revenue
- An opioid epidemic, firearm violence, and rising suicide rates
- Lack of affordable health insurance coverage
- Climbing rates of obesity
- Unacceptable levels of infant mortality
- Decades of underinvestment in our human capital via education and job training, as well as basic community infrastructures that support health
- Inadequate access to clinical care
- A fraying social safety net

With permission, Robert Hughes, December 2017. <https://mffh.org/news/why-isnt-health-a-greater-priority-in-missouri/>



# Missouri Health Assessment, 2012

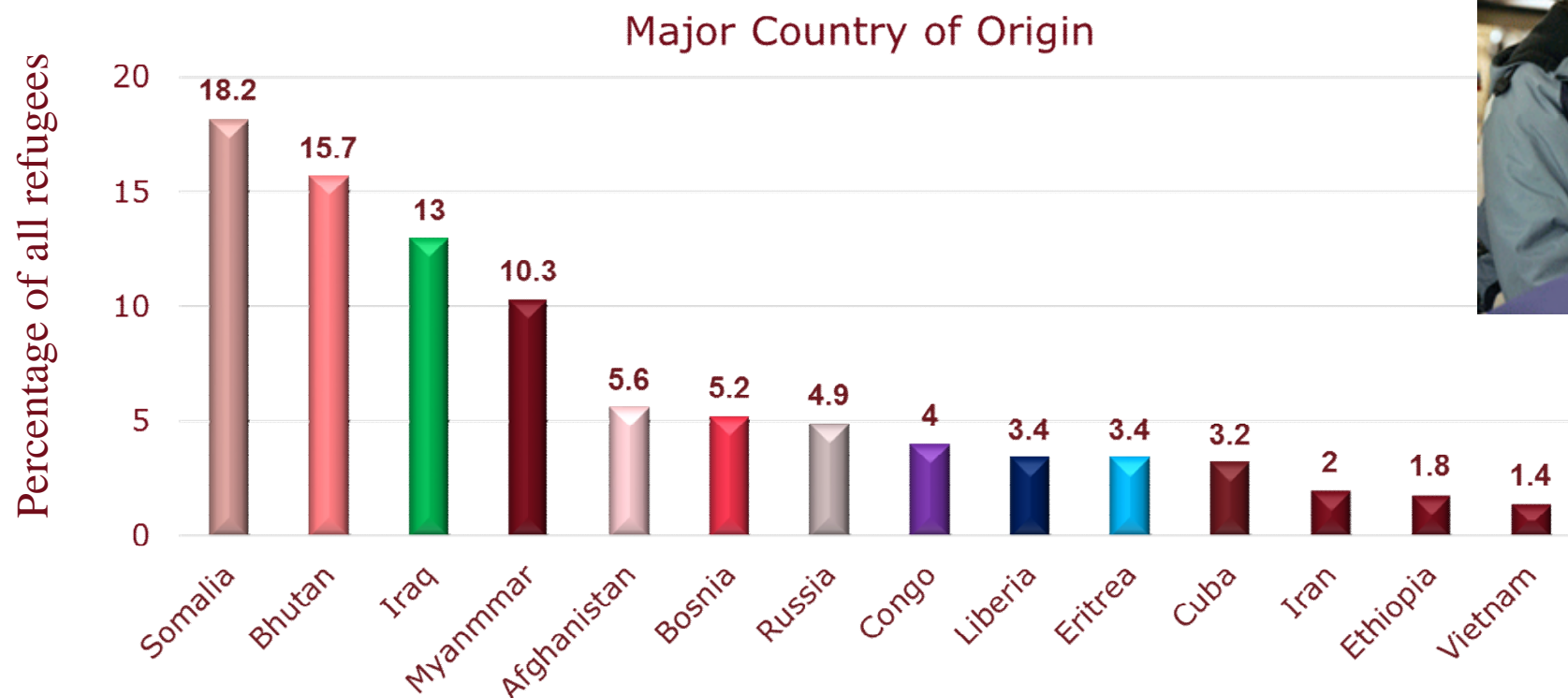


# St. Louis Area Health Challenges

- Racial Distrust
- Limited public awareness, knowledge, unhealthy behaviors
- Limited dedicated funding
- Significant infrastructure needs
- Low levels of coordination
- Information systems sub-standard
- Decaying urban core



# Refugees Processed in St. Louis: 2015



Source. U.S. Department of State Refugee Processing Center, 2015

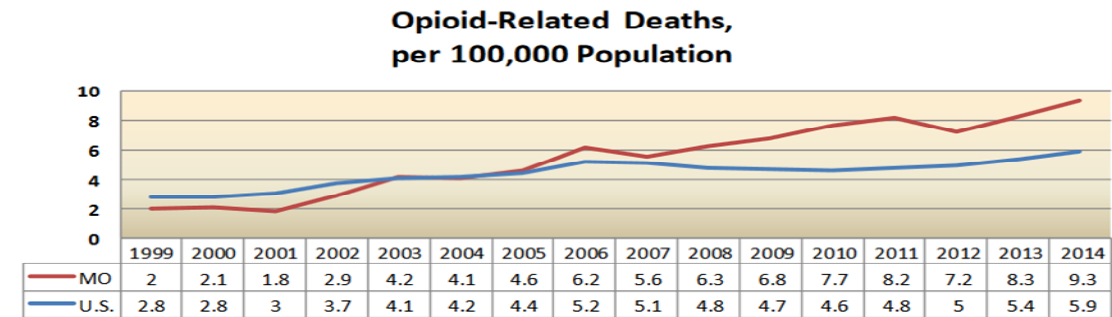


# A Mass Killer: St. Louis heroin deaths hit new high

From the Heroin's impact on region is far-reaching series. By Jesse Bogan • St. Louis Post-Dispatch Feb 20, 2017



Photo by David Carson, dcarson@post-dispatch.com



[http://www.stltoday.com/news/local/metro/a-mass-killer-st-louis-heroin-deaths-hit-new-high/article\\_2fd6130c-3c35-524a-891e-e51eff2e40b4.html](http://www.stltoday.com/news/local/metro/a-mass-killer-st-louis-heroin-deaths-hit-new-high/article_2fd6130c-3c35-524a-891e-e51eff2e40b4.html).

**A 13 year-old African American female is seen in the emergency department with recurrent diabetic ketoacidosis. What factor would you consider in explaining her non-adherence to her diabetic regimen?**

Underlying depression

High health literacy

Stable relationship with parents

Too many Insulin preparations to choose from

## Case 1: Methanol Intoxication in Native American Male

BS is a 35 year-old Native American male, recently released from federal prison in September 2016. He was admitted to Barnes-Jewish Hospital with complaints of abdominal pain and hematemesis. He also reported blurry vision in his left eye and believed it was due to “a demon attacking his eye”. He admitted to huffing (inhaling) carburetor fluid for last several days. He acknowledges that he has an addiction to huffing and has tried various rehab programs in the past, but has always relapsed. He had been doing this routinely when he was in Tulsa prior to his incarceration and recalls being admitted to Regional Hospital in Tulsa on at least 3 occasions with symptoms. He is currently homeless and says he has been stranded here since he was released from prison and is trying to get back to Tulsa. In the hospital he was physically disheveled, with a SBP 90. He was noted to have an Anion Gap of 34, and HCO<sub>3</sub> of 11. When the Renal team arrived to see the patient, they noted that all the medical and nursing staff taking care of the patient were wearing isolation gowns and gloves, although there was no isolation sign on the door. He underwent hemodialysis for presumed methanol intoxication. Volatility panel returned with an elevated methanol level of 46. He was subsequently treated with fomepizole. Repeat methanol level was undetectable. His metabolic acidosis resolved, as did his hematemesis, but his blurred vision persisted. The patient was counseled on the importance of avoiding further huffing/substance abuse habits. He stated he would take his chances with living on the street because no one in the hospital respected him. He subsequently signed out the hospital AMA.

There are many issues regarding professionalism and cross-cultural communications in this patient scenario.

1. First among them, why did the patient sense he was not treated with respect? Well, the cues could not have been more obvious. It was widely circulated among the staff that he was recently released from prison, and he was repeatedly asked what his offense was. Even after he was cleaned up and documented to not have an infection risk his medical and nursing team never made contact with him unless they were gowned and gloved. He felt like an “untouchable”. Last, he had presented similarly to an outside hospital and had been treated without the delays he currently experienced. While no overt words were spoken, the body language, or hidden curriculum, spoken from attendings to medical students, was that this was a patient who had caused his own problems.

## Case 1, con't

2. There were few, if any attempts to understand the patient's perspective on his illness and his drug addiction. From the standpoint of trauma-informed care, an opportunity was missed to ask the patient, "what happened?" instead of "why are you here?" It is quite probable that a homeless Native American male with substance abuse has encountered several adverse events in his life and could benefit from trauma-specific care. Trauma-specific intervention programs generally recognize the following:

- ☐ The individual's need to be respected, informed, connected, and hopeful regarding their own recovery
- ☐ The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety
- ☐ The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors

## Case 1, con't

3. The trauma-informed perspective is also related to the need to understand the patient's perspective of their illness using the Arthur Kleinman Explanatory Model. This is particularly relevant in this case because the patient assumes that his illness is the result of a demon attacking him because he had wronged someone in the past. Thus, it is his "fate" that he slowly loose his vision, his kidney function, and remain addicted to huffing. By adopting the Explanatory Model and asking "what caused your disease," the health professional can begin to build trust, engage in effective cross-cultural communication," and find a common ground that will allow the patient to incorporate medical constructs into his more spiritual, non-medical view of disease. By building more trust and respect, it is quite likely the patient would not have signed out of the hospital and would have been more amenable to input from social services.

# The LEARN Communication Model

## 1. Listen

Listen with empathy and understanding to your patient's perception of the problem. Encourage your patient to discuss his understanding of the causes and effects of his illness and to describe the treatment and resources he feels will contribute to recovery. "What do you feel may be causing your problem?" is an example of a question that elicit patient feedback.

## 2. Explain

Explain your patient's illness, the recommended plan of care and subsequent management of self-care. Even without a diagnosis, it is essential that you explain what you have in mind in terms the patient can understand. Take into account literacy level, cultural beliefs, and past experiences which may affect understanding and acceptance of any suggestions you give. Try to link your explanation to something the patient already knows.

## 3. Acknowledge

Acknowledge your patient's feedback and understanding of his illness and plan of care. Discussing the differences and similarities with your observations will help promote patient involvement. Areas you agree upon should be recognized and differences resolved. Whenever possible, integrate your patient's suggestions into any care approach. This will give him a sense of control and commitment.

## 4. Recommend

Recommend a plan of care that fits within the patient's parameters. This can be accomplished after completing the 3 previous steps. The more involved your patient is in the development of his plan of care, the more interested he will be in its outcome.

## 5. Negotiate

Negotiate agreement with your patient on a course of action. This requires a keen understanding of your patient's perspective and the ability to integrate the information you gained in the previous 4 steps. Successful completion of this final and key step can lead to a variety of patient-specific approaches that will increase the change of a successful recovery and healthier life.

Berlin EA. & Fowkes WC. (1983). A teaching framework for cross cultural health care: Application in family practice. West J. Med. 12(139), 93-98.)



**While you are rounding in the hospital, an intern makes an outrageous statement disparaging a 16 year-old obese female patient. The medical students on the team are aghast at the statement. You go to the residency director and request that ...**

The intern be placed on immediate leave

The housestaff participate in case-based diversity awareness sessions led by the hospital's diversity trainers

The resident who made the remarks be required to take the Implicit Association Test

The intern get assigned to another attending



## CASE STUDY 2

A 31-year-old Guatemalan immigrant was admitted to Barnes-Jewish Hospital with profound weight loss, cough, fever, and night sweats. A chest X-ray confirmed diffuse pulmonary infiltrates, and sputum samples returned positive for *M. tuberculosis*. The patient, who had newly immigrated to St. Louis to work as a groundskeeper and spoke minimal English, agreed to enter into a TB sanatorium to complete six months of directly-observed anti-tuberculosis medication. However he refused to provide information on household contacts. The social worker disclosed that he resided in a living facility with twelve other residents, also recent immigrants. The patient has since relocated to the TB sanatorium in Kentucky; however the health department has so far been unsuccessful in identifying his contacts. What options would you have considered in gaining the patient's trust to proceed with contact tracing?

## CASE STUDY 3

ZS is a 28-year-old Afghan male who presented with a large right-sided pelvic mass. A subsequent biopsy confirmed a diagnosis of lymphoma. The patient was seen by Oncology and was being managed with IV hydration and IV morphine through patient-controlled analgesia (PCA). While the patient was undergoing assisted ambulation by physical therapy, he joked that the trigger on his PCA pump resembled a detonator for the bomb on a suicide vest. The physical therapist, taken aback by the comment, referred the comment to the nurse manager, who immediately contacted security. The patient was confronted by two security guards, who secured the patient in his room and spent over an hour questioning him before concluding the patient was not a security risk. On the following day, the patient and his family demanded an apology from the attending physician and the hospital president; otherwise they would contact the news media and complain that Barnes-Jewish Hospital promoted racist and culturally insensitive practices. You are the attending, what is your response?

**A 12 year-old Thai girl with juvenile arthritis is seen in the hospital with erythematous, circular lesions on her back and abdomen. You suspect her parents have engaged in a ritual called cupping to help alleviate the child's pain. Your response ...**

Explain to the parents that you understand their desires to help their daughter, but that you have more effective therapies to treat her

Report the case to social services

Call a psychiatrist

Bring in a respected family member or support person to make sure that you are communicating effectively with the family

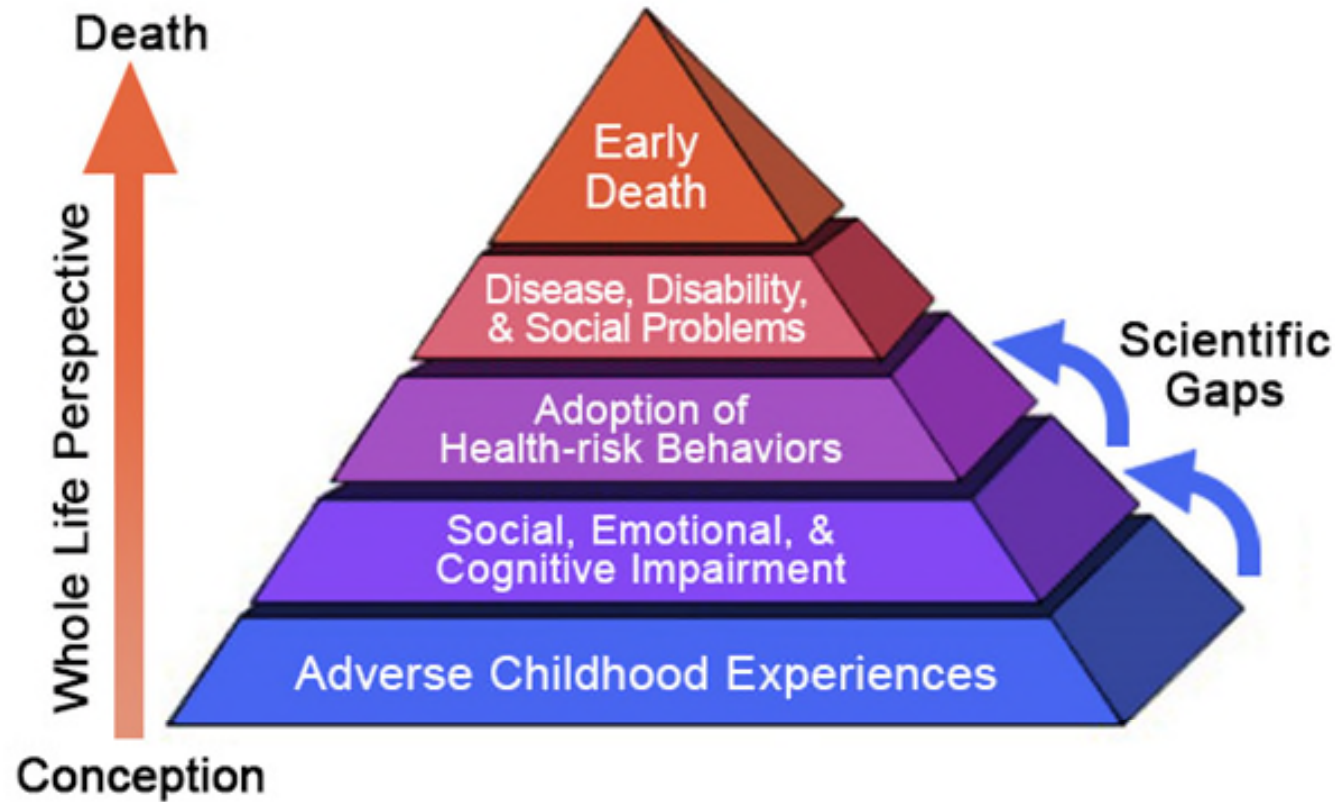
## CASE STUDY 4

A 17-year-old African-American male with sickle cell disease presents with severe pain crisis. This is his twentieth visit to Children's and Barnes-Jewish Hospital over the past year. During the current admission he required such large doses of IV Dilaudid that the medical team became suspicious that he was drug seeking. The medical team attempted to reduce his IV meds while preparing to discharge him. When the attending physician took over his care he found out indeed the patient had been in and out of the hospital several times over the past year with the same complaints, but on further exploration noted he also showed signs of major depression and anxiety. Upon questioning he states he has little social support and basically manages his disease alone. Furthermore, he confided that he had sex with men but did not consider himself homosexual. This was quite an anxiety-provoking issue since he lived in a very "macho" community. How would you now approach this case? How could we have helped the medical team acknowledge their implicit biases towards the patient? How could we have captured the relevant social history so that future providers would understand the context of his illness?

## CASE STUDY 4

G. H. is a 24-year-old African American male who was readmitted to Barnes-Jewish Hospital after complications from a gunshot wound to the abdomen. He had suffered extensive colon damage requiring a colostomy and nephrectomy, with subsequent development of acute kidney injury. His colostomy was complicated by poor wound healing and an enterocutaneous fistula. He has no significant past medical history. He grew up in the Fairground Park neighborhood (63117 zip code). He graduated from high school but never attended college and worked sporadically as an auto mechanic. His medications included broad spectrum antibiotics. He was receiving TPN. On examination, he was a thin, ill-appearing male. He had an extensive abdominal wound with a wound vacuum draining a large cutaneous fistula, with a noticeable 5.7 L colonic output over the past 24 hours. His labs were remarkable for a K 2.4 mEq/L, HCO<sub>3</sub> 13 mEq/L, and Cr 2.5 mg/dl. When the medicine team started to discuss scheduling of his colonic fistula repair with surgery, the patient was dismissive of the intervention and instead stated: “I know who shot me and they are going to pay.” How do you approach this case? Do you pursue opportunities to interrupt the cycle of gun violence with the social worker, or do you focus solely on the immediate medical needs? How do you gain his confidence and trust to engage in the medical treatment plan?

# Adverse Childhood Experiences – The Roots of Allostatic Load



Parents Divorced/Separated  
Residential Instability  
Domestic Violence Witness  
Child Protective Services Involved  
Jailed Family Member  
Substance Abuse in Family Member  
Basic Needs  
Mental Health Disorder in Family Member  
Physical Disability in Family Member  
Community Violence Exposure  
Parent/Caregiver Death

American Journal of Preventive Medicine in 1998, Volume 14, pages 245–258. <http://acestudy.org/index.html>



# An advantage of working in a diverse and inclusive environment is ...

Evaluating your peers' biases

Gaining a competitive edge for  
your next employment

Gaining additional knowledge and  
respect of different cultures

Becoming culturally competent in  
a different culture

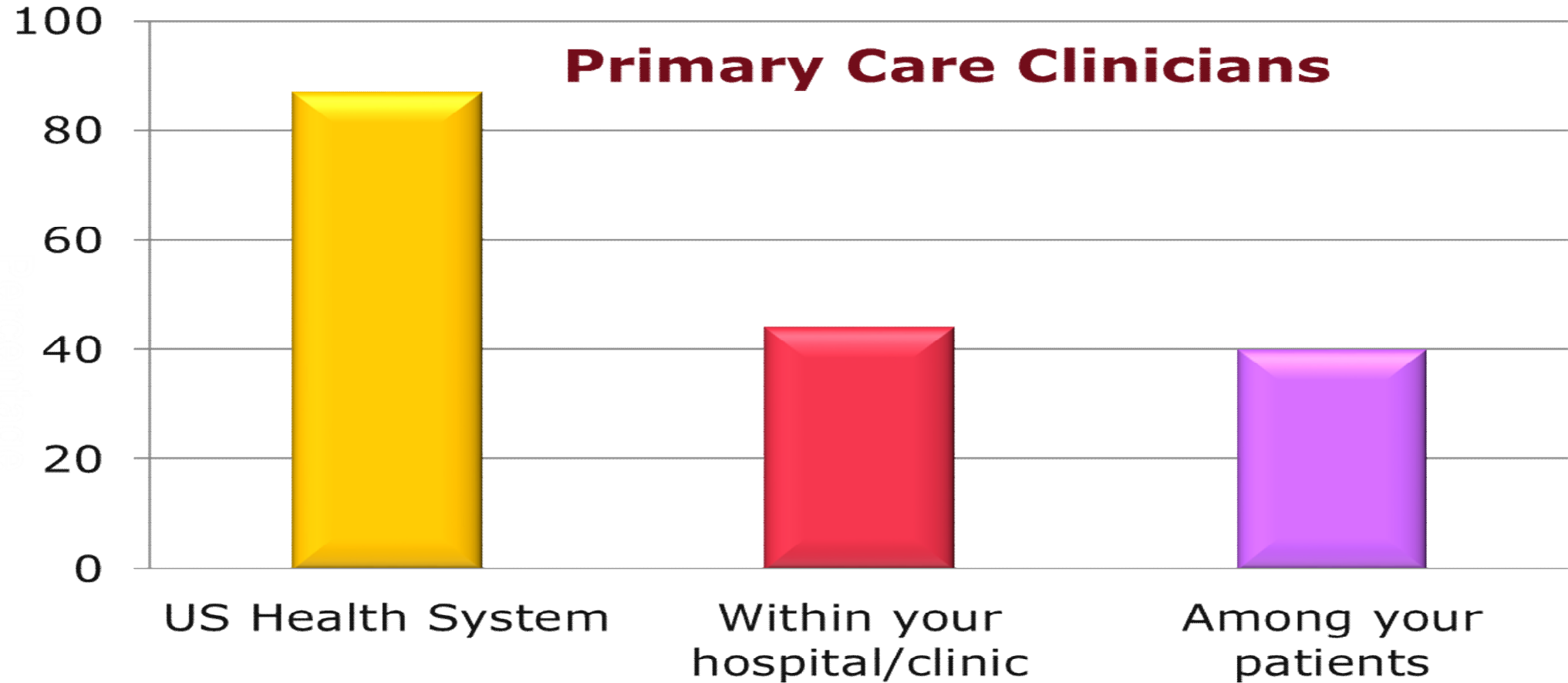
# Recognizing Our Blind Spot

Almost 8 of 10 white practitioners believe that disparities in how people are treated within the health care system “rarely” or “never” happens based on factors such as fluency in English or racial and ethnic background.

Kaiser Family Foundation 2001 Report: National Survey of Physicians



# Physician Acknowledgement of the Existence of Racial Disparities in Care



*J. Gen Intern Med 23:678-84. 2008*

# False Beliefs Persist Among US Residents and Medical Students

**Table 1. Percentage of white participants endorsing beliefs about biological differences between blacks and whites**

Item	Study 1: Online sample (n = 92)	Study 2			
		First years (n = 63)	Second years (n = 72)	Third years (n = 59)	Residents (n = 28)
<b>Blacks age more slowly than whites</b>	23	21	28	12	14
<b>Blacks' nerve endings are less sensitive than whites'</b>	20	8	14	0	4
<b>Black people's blood coagulates more quickly than whites'</b>	39	29	17	3	4
<b>Whites have larger brains than blacks</b>	12	2	1	0	0
Whites are less susceptible to heart disease than blacks*	43	63	83	66	50
Blacks are less likely to contract spinal cord diseases*	42	46	67	56	57
<b>Whites have a better sense of hearing compared with blacks</b>	10	3	7	0	0
<b>Blacks' skin is thicker than whites'</b>	58	40	42	22	25
Blacks have denser, stronger bones than whites*	39	25	78	41	29
<b>Blacks have a more sensitive sense of smell than whites</b>	20	10	18	3	7
<b>Whites have a more efficient respiratory system than blacks</b>	16	8	3	2	4
<b>Black couples are significantly more fertile than white couples</b>	17	10	15	2	7
<b>Whites are less likely to have a stroke than blacks*</b>	29	49	63	44	46
<b>Blacks are better at detecting movement than whites</b>	18	14	15	5	11
<b>Blacks have stronger immune systems than whites</b>	14	21	15	3	4
False beliefs composite (11 items), mean (SD)	22.43 (22.93)	14.86 (19.48)	15.91 (19.34)	4.78 (9.89)	7.14 (14.50)
Range	0–100	0–81.82	0–90.91	0–54.55	0–63.64
Combined mean (SD) (medical sample only)			11.55 (17.38)		

For ease of presentation, we shortened the items; see [SI Text](#) for full items and additional information. For ease of interpretation and ease of presentation, we collapsed the scale and coded responses marked as possibly, probably, or definitely untrue as 0 and possibly, probably, or definitely true, as 1, resulting in percentages of individuals who endorsed each item. Bold entries represent the items included in the false beliefs about biological differences between blacks and whites composite.

\*Items that are factual or true.

# Inclusion involves leveraging diversity to create an institutional environment that is ...

Reflective of the general demographics of the country

Collaborative

Focused on competition

More focused on team-building than outcomes

# Ten Strategies for Effective Cross Cultural Communication

- Ask Questions
- Distinguish Perspectives
- Build Self-awareness
- Recognize the Complexity
- Avoid Stereotyping
- Respect Differences
- Listen Actively
- Be Honest
- Be Flexible
- Think Twice



## Effective Cross Cultural Communication is a core aspect of patient-centered care

“As doctors, our ethics are tested every day of our careers—not only in the care decisions we make but also in how we speak to and about our patients, in how we interact with our colleagues and learners, and in the steps we take to help those in our communities live healthier, longer lives.”



Darrell G. Kirch, MD, AAMC President and CEO

# Successful cultural awareness training ...

Involves critiquing cultures outside your own

Disdains working in community-based settings

Includes formal curriculum with patient-based scenarios and reflective encounters

Is accentuated by isolated workshops with your peers



# Questions?

