Chapter e3: Exploring Cultural Diversity and Equity in Healthcare

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KEY CONCEPTS

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1. Healthcare providers should strive toward cultural competency and equity in the context of social determinants of health and community history to improve care and access unique resources for patients and communities from diverse cultures and backgrounds.
2. Changes in demographics in the United States, health disparities, patient safety, and healthcare workforce shortages are among the reasons for needing cultural and linguistic competency skills and for promoting diversity and equity in healthcare.
3. A variety of models recognize cultural competency as a process, not an achievement.
4. Legal and regulatory issues surrounding cultural competency include understanding and interpreting accreditation standards for healthcare organizations and Title VI of the Civil Rights Act.
5. Patients may enter the healthcare setting with a different explanation of their illnesses than what is found in the Western biomedical model (WBM).
6. Cultural values and beliefs influence decisions and attitudes about healthcare, including race, ethnicity, age, gender, sexual orientation, and religious beliefs.
7. Developing communication skills to interact with diverse populations involves recognizing personal styles and cultural values of communication as well as barriers to patient understanding.
8. Linguistic competency encompasses understanding the capacity of organizations and providers to communicate well with diverse populations such as patients with limited English proficiency (LEP), low literacy, or hearing impairments.
9. Before practitioners can understand other cultures, they should strive to understand the personal and organizational values and beliefs.
10. Skills for working with patients from diverse cultures include being able to listen to the patient's perception of health, acknowledging differences, being respectful, and negotiating treatment options.

BEYOND THE BOOK

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Select any one of the patients from diverse backgrounds from the cases introduced in the first section of this chapter. What are the factors that influence their health that are based on genetics? Individual and family choices? Community influences? Larger city and policy structures?

For more in-depth discussions, consider these activities and questions:

1. Use Healthy People 2030 (https://health.gov/healthypeople/objectives-and-data/browse-objectives) to identify Social Determinants of Health found in the cases.
2. Describe what you think would be the acculturation of each patient. What is the host culture? What is the home culture?
3. Explore values and beliefs found in resources provided in the chapter: Based on the information provided, what social identity and acculturation characteristics are involved? Look up information about healthcare beliefs and values based on how the patient self-identifies with religion and race or ethnicity.
4. Discuss what you would describe to be your own "cultural competency" to work with each of the patients. Which models do you prefer?
5. If approached by one of the patients, providers may argue that "we can't solve everything in healthcare. I only have so much time during a visit." How might you respond to those statements? What changes can be made at a provider level, clinic/hospital level, and at a larger system-wide level to improve care across cultures?

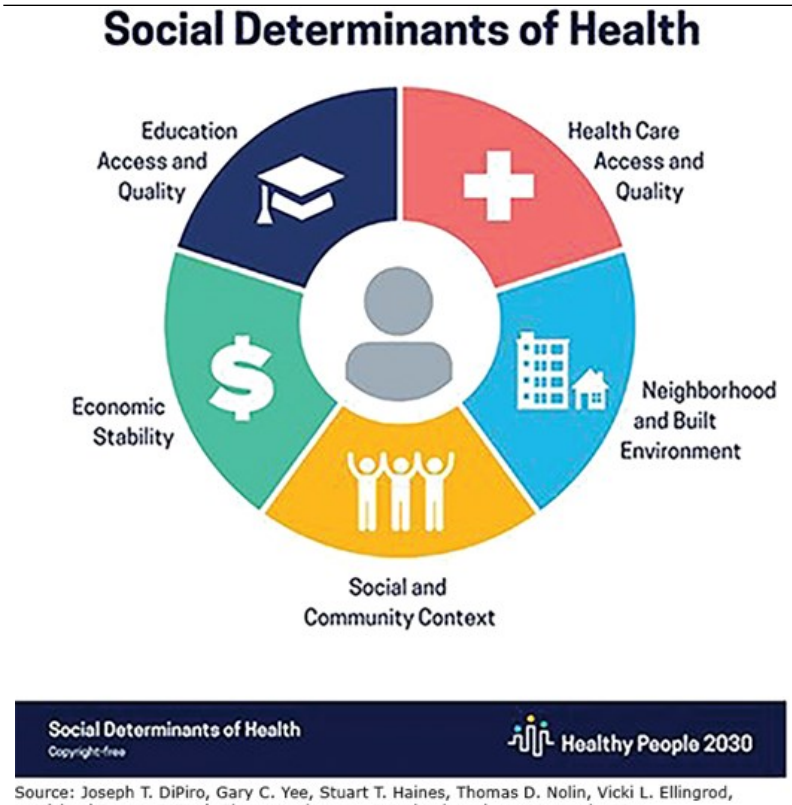
CULTURE, COMMUNITY, AND SOCIAL DETERMINANTS OF HEALTH

Culture influences who we are, including our thoughts, behaviors, and beliefs toward healthcare. What is culture? **Culture** can be defined as "the learned and shared beliefs, feelings, and knowledge that individuals and/or groups use to guide their behavior and define their reality as they interact with the world."[1,2]

Social determinants of health are also of great influence, and unlike a person's genetic makeup, which is largely nonmodifiable, social determinants of health can be addressed. Determinants of health describe the factors that affect a wide range of outcomes and risks associated with the quality of life, functioning, and health of individuals (Fig. e3-1). Each person's health outcomes are influenced by factors based on the places where they live, work, worship, or play and their structural environment (eg, sidewalks, exposure to clean air, access to quality education and healthcare, social norms, and attitudes such as racism and discrimination).[3] According to the Robert Wood Johnson Foundation County Health Rankings, individual lifestyle choices comprise approximately 20% of the determinants of health outcomes; clinical care also makes up 20%, while social and economic factors (40%) in addition to physical environment (10%) make up half of the factors influencing health outcomes.[4] Basically, our identities such as socioeconomic status, race and ethnicity, gender, age, and environments, as part of our cultures, shape us and can play a major role in our overall health status.[5]

FIGURE e3-1

Social determinants of health. *(Data from US Dept. Health & Human Services, Office of Disease Prevention and Health Promotion, https://health.gov/healthypeople/objectives-and-data/social-determinants-health, Accessed August 3, 2021.)*



Source: Joseph T. DiPiro, Gary C. Yee, Stuart T. Haines, Thomas D. Nolin, Vicki L. Ellingrod, L. Michael Posey: *DiPiro's Pharmacotherapy: A Pathophysiologic Approach, 12e*

Consider the following brief descriptions of three individuals and the determinants of health that influence them.

Patient 1 is a 42-year-old bilingual Vietnamese American, Buddhist woman living on the West Coast whose family immigrated to the United States 35 years ago. Her lifestyle choices include a vegetarian diet, gardening, and daily meditation. She lives in a suburban community with her husband and three children, drives a hybrid electric/gas car to her work as a schoolteacher and purchases food from a local farmer's market. She has health insurance, and her city public policy includes no indoor smoking in public places and state policies include special low-emission requirements on vehicles. Weekend activities with the family include sports and dance for the kids along with others from the community center that serves several Asian American families.

Patient 2 is a 27-year-old single African American, Muslim upper-middle-class man living in a major city in the Eastern Coast of the United States. Having just finished his graduate school degree, he lives in a high-rise apartment and walks or rides the subway to his work at a major corporation. In his leisure time, he enjoys reading and going to major sporting events with his college friends who come from diverse backgrounds. During the week, he also frequents the local mosque and community events that are supported by his neighborhood.

Patient 3 is a 55-year-old European American, Protestant middle class man living in the Midwest. He identifies as gay and is in a monogamous relationship with his partner for 5 years. Due to recent economic changes in the community, he now must work three part-time jobs (two in food industry and one in construction) so that he can help support his partner who is undergoing cancer treatment for lymphoma. As a result of his high work demands, he is not able to shop for groceries or exercise and so the couple often eats away from the home, or they prepare quick and processed meals at home. He notices that he has gained about 10 pounds (4.5 kg) in the past 6 months and has difficulty sleeping. The family also has not had time to connect with their church or other friends due to his work and doctor appointments for his partner.

Can healthcare professionals assume that these three patients have the same healthcare beliefs, values, and approach to healthcare? While each of the patients described above will have a unique health situation, social determinants will influence their exposure to health disparities or inequities and their cultural backgrounds will also shape their health beliefs and behaviors.[6]

As healthcare organizations and practitioners seek ways to improve health equity and quality across populations, they can develop their cultural and linguistic competencies. To engage with and serve patients from diverse cultures, each healthcare practitioner should have **cultural humility**, or be a

part of a "lifelong process of self-reflection and discovery to understand one's own culture as well as another's culture, by starting with a critique of his/her/their own beliefs and cultural identities."[7]

Cultural competency may be described as the attitudes, knowledge, skills, and values that an individual has and uses in working effectively in a cross-cultural environment.[8,9] At an organizational level, cultural competency can be demonstrated by an organization having a defined set of values and principles (mission), policies, and structures for service delivery that incorporate community input and enable individuals in the organization to work effectively within cultures and cross-culturally.[2,8]

Linguistic competency is linked to cultural competency. It describes the "capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences" (eg, persons of LEP, those who have low literacy skills, individuals with different hearing or sight abilities).[9]

The environments we live in—our communities—also define our health.[5,6,10] Research suggests that while we should address health at the individual level, providers and policymakers must also understand and address healthcare at the community and population level.[11,12] But what creates a community? **Communities** may be defined as organized groups of people with a shared identity that *may exist around* racial and ethnic groups, socioeconomic position, religion, age, gender, language, as well as other cultural ties.[13] Communities can also cut across these variables. **Community competency** encompasses cultural competency; however, it also recognizes the unique role of communities as a type of culture.[13] Within a community competency framework, clinicians will understand that at the core of a community are ***history, context, geography, and culture***.[13] For example, given similar socioeconomic and educational backgrounds, an adolescent male raised in Chicago, Illinois, whose family is from Puerto Rico would have a different life experience (ie, a different community or environmental influence) than an adolescent male of a similar family background being raised in Greenville, South Carolina.

History helps describe the collective consciousness of a community. For example, a community's recent history may include the devastation of a flood or tornado. Political history can affect a refugee population's experience and the history of slavery in the United States affects multiple communities. The history of a community is not always considered in social determinants of health models but understanding the history can enhance evaluating the social determinants of health. ***Context*** acknowledges the present situation of a community such as the quality of education, housing, or healthcare. ***Geography*** helps to distinguish differences between a male of Islamic religion and Somali descent who is raised in Philadelphia, Pennsylvania, from one who is raised in St. Paul, Minnesota.

What is the difference between cultural and community competency? Cultural competency helps clinicians understand the individual; thus, "culturally competent care can be considered patient-centered care."[13,14] Community competency provides a broader context for clinicians to work with individuals and families, as it incorporates the influence of the population and environment on the individual. Although this chapter focuses on cultural competency and care of individuals, acknowledging the influence of community on individuals is significant.

1 Healthcare providers should strive toward cultural competency and equity in the context of social determinants of health and community history to improve care and access unique resources for patients and communities from diverse cultures and backgrounds. This skill is increasingly important to healthcare practice as our society becomes more and more diverse. The healthcare provider tries to negotiate an approach to treatment that is respectful of patient beliefs, while integrating an effective course of therapy in a manner consistent with the patient's beliefs and understanding. This approach does not devalue the patient's cultural and community beliefs. As a result, better treatment adherence can occur.[15] The negotiation between provider and patient is the art of patient care and is a skill that requires continual practice.

A more culturally competent approach to care integrates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to culturally unique needs of the patient.[2,8,15] In short, there is respectful acknowledgment of the patient's belief system. A culturally competent approach to care includes a set of behaviors and attitudes that enable a healthcare provider to work effectively in cross-cultural situations with humility, sensitivity, and cultural awareness.

Reasons for Cultural Competency and Promoting Diversity in Healthcare

2 Changes in demographics, health disparities, patient safety, and healthcare workforce shortages are among the reasons for needing cultural and

linguistic competency skills and promoting diversity and equity in healthcare.[15] In this section, the situation as it exists in the United States is detailed. The central concepts would be similar for other countries around the world, even though some of the specifics would vary.

The United States is diverse.[16] Approximately 42% of the population identifies as Black or African American, Hispanic, Asian, American Indian, being of another race that is not White, or as coming from two or more races.[16] The United States is aging, with 16.5% of the population reported as being 65 years of age or older.[16] Furthermore, people have diverse religions, languages, and countries of origin. Nearly 75% of adults in the United States report identifying with a particular faith or religious group.[17] At least 350 distinct languages are spoken in US homes.[18] The three patients described in the beginning of this chapter highlight some of the diversity that might be encountered throughout United States.

Regrettably, health disparities generally occur in populations who have systematically experienced a social, economic, or environmental disadvantage in society. While disparities are often linked to differences in race and cultural backgrounds, they also exist among groups based on religion, ability status, sexual orientation, and age, among other characteristics. **Health disparities** refer to gaps in the quality of health and healthcare and can include differences in rates of disease or illness, access to healthcare, or general health outcomes.[19] One of the overarching goals of Healthy People 2030 (Table e3-1), which frames the national health agenda, is to eliminate health disparities that exist in our population and achieve health equity.[3]

TABLE e3-1

Overarching Goals of Healthy People 2030

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Data from US Department of Health and Human Services, July 14, 2021.

Health disparities may vary based on the population and the health outcome measured. For example, adults in the United States who are African American experience higher mortality rates of heart disease compared to non-Hispanic Whites.[20] Diabetes prevalence rates are greater among adults with lower household incomes, Hispanics, and African Americans than among Asians and non-Hispanic Whites. Suicide rates are higher among men than women, with elevated rates found in American Indians/Alaska Natives as well as Lesbian, Gay, Bisexual, and Transgender (LGBT) youth.[21,22] Smoking prevalence is higher among adults who have not graduated from high school when compared with adults with a college degree.[23] These statistics and others like them underscore the need for improvements in the quality of healthcare for historically marginalized groups.

Health disparities or inequities persist due to existing social determinants of health that result from both historical and contemporary discrimination and structural barriers in society. Disparities in physical environment, social, and economic factors exist in racial/ethnic minority groups. These differences are rooted in structural racism in the society and nation that originated hundreds of years ago and is still experienced present-day.

Structural racism is the normalization and legitimization of historical, cultural, institutional, and interpersonal dynamics that, in the United States, have routinely led to advantages among White populations while producing cumulative and chronic adverse outcomes for people and communities of color.[24] Minorities have been subjected to marginalization within society in forms ranging from genocide and slavery to exclusionary policies and practices that continue today.

Segregated neighborhoods resulted in lack of generated wealth and greater exposure to environmental pollution for minorities, increasing their likelihood of pulmonary conditions and lower life expectancy. These under-resourced neighborhoods also have under-resourced schools, limited access to hospitals, physicians, and pharmacists, and limited healthy food options. Discrimination in the workplace, healthcare, and society can result in racial/ethnic minority individuals receiving subpar healthcare, job opportunities, higher education and can overall result in greater stress and

trauma, putting patients at greater risk for disease states such as hypertension and heart disease.

Because of societal and cultural norms in the United States, some individuals are treated differently and unfairly based on their physical characteristics. This unfavorable treatment can be referred to as **explicit (conscious) or implicit (unconscious) bias**.[25] Bias is a prejudice in favor of or against a person or group compared to another, usually in an unfair way. Our biases and prejudices can be shaped by our socialization,[26] which is the process of being exposed or taught (whether overtly or covertly) societal norms and consciously or unconsciously using this information to guide our behaviors and beliefs.[25,27] Implicit biases can contribute to health disparities, affect the patient-provider relationship, contribute to patients' lack of trust, and decrease overall patient health outcomes.

A healthcare provider's cultural competency can help to address health disparities in their communities and empower patients from minority groups to improve their health.[28,29] By understanding the needs of underserved patients and by identifying the unique resources available within these populations, the healthcare provider can positively impact patient's healthcare experience. For example, a healthcare provider who understands the importance of community support in a Latino patient seeking healthcare can include a key community member (eg, a *promotora* or community health worker) as an active advocate for prevention measures, treatment, or posttreatment care.[30,31] By working within the patient's cultural needs and expectations, the provider can use otherwise overlooked support systems (eg, family, neighborhood friends, and religious ties) in a community with fewer or overtaxed resources. Using cultural competency skills to better identify cultural and community assets in minority and underserved populations allows the provider to go beyond basic awareness of and sensitivity to cultural differences to increase a patient's adherence with treatment and positively impact patient health outcomes.[32] Additionally, the provider's ability to empower patients through cultural competency will facilitate the development of trusting patient/community/provider relationships.[33]

Culture and language may also play a role in patient safety.[34] Errors and adverse events can occur because of differences in language between healthcare providers and patients, ineffective use of an interpreter, or inadequate translation of written material related to health. Poor judgment or lack of adherence to a treatment plan can occur because of discordance in a patient's cultural health belief system. Cultural "incongruences" among patients and providers may lead to making judgments about a patient's decision to use complementary and alternative medicine (CAM) or casting stereotypes based on personal biases about healthcare.[14]

While some areas of the country may have a surplus of providers, there are still shortages in healthcare providers across disciplines as well as lack of diversity among providers, which contributes to health disparities.[35] More than 65 million Americans live in areas that are designated by the Health Resources and Services Administration (HRSA) as primary care health professional shortage areas.[36,37]

To meet the healthcare needs of a multicultural society, there is a compelling need to equip current and new providers with the skills to provide a culturally competent approach to care. The education and recruitment of a culturally diverse workforce can lead to greater provider-patient concordance (ie, ability for a patient to consult with a provider of similar cultural or linguistic background).[37,38]

Given the dynamic shifts in demographics in the United States and contrasts in health equity across cultures, healthcare providers cannot ignore the effects of culture on healthcare. If the healthcare system does not acknowledge and address cultural influences in patient care, patient safety can be compromised. Opportunities exist for educating providers and recruiting a more diverse workforce to care for society.

CULTURAL COMPETENCY MODELS

3 Several models have been used in healthcare to describe and understand cultural competency: the Cultural Competence Continuum by Terry Cross, the Purnell Model for Cultural Competence by Larry Purnell, and the Process of Cultural Competence in Delivery of Healthcare Services by Josepha Campinha-Bacote.[39-41] Across these models, a salient theme surfaces—cultural competency is a process rather than an achievement.[39-41] As practitioners participate in a lifetime process of development, employing cultural humility, and not making assumptions about their own skills can be helpful for working across cultures.[7]

In the **Cross Cultural Competence Continuum**, six stages are described in a stepladder model starting with cultural destructiveness and ascending toward cultural proficiency.[40] *Cultural destructiveness* in healthcare occurs when a person or an organization actively devalues or berates patients or a community based on their cultural background (eg, race, language, and religion). When persons or organizations are willing but unable to support

culturally oriented practices, they demonstrate *cultural incapacity*. *Cultural blindness* results from an effort to treat every patient or family the same regardless of culture. However, the provider or organization can miss key elements in the patient's healthcare behavior that are attributable to their culture. Treating patients equally does not necessarily signify that patients should be treated the same. In *cultural precompetency*, individuals and organizational leaders recognize that culture is influential in healthcare and efforts are made to improve and adapt care related to culture. In this stage, providers and organizations often believe that making a few adjustments or changes in practice or policy to improve care to diverse cultures are sufficient. However, they do not embark on a continuous improvement plan.

Although cultural competency can really never be achieved, individuals and organizations demonstrating traits of *cultural competency* will value diversity and seek to continuously implement and evaluate new ideas and programs to improve their care to patients and families from different cultures. Those providers and organizations considered to be more *culturally proficient* will be viewed as leaders at the forefront of cultural competency who are actively educating others or conducting research in the field.

The **Purnell model** explores the relationship of family, community, and the global society as they influence the individual person.[39] The model further outlines 12 different cultural beliefs and traits that may affect the individual and are often interconnected, such as healthcare practices, spirituality, communication styles, and workforce issues. In this model, Purnell illustrates that healthcare providers and organizational leaders often experience a learning process related to their cultural consciousness. In this continuum, providers may move from being unconsciously incompetent (not aware of lack of competence), consciously incompetent (aware of lack of competence), consciously competent (aware of improving competence) toward unconscious competence. When a provider is unconsciously competent, they have been able to integrate skills, knowledge, and awareness of the varying cultural, familial, and broader community influences on a patient with fluency.

In the **Campinha-Bacote model**, five constructs with an interdependent relationship describe the development of a process of cultural competence infused with cultural humility: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.[42] Cutting across all of these constructs is a sense of *cultural humility,* where practitioners have an understanding of social inequalities while demonstrating a deep and genuine commitment to kindness and social justice. By self-assessment of cultural and professional biases and beliefs, clinicians develop increased *cultural awareness*. This self-awareness helps clinicians to recognize the risk of imposing personal beliefs in patient care. As clinicians learn more about beliefs and practice, disease epidemiology, and the efficacy and acceptance of therapies that are found in diverse cultures, they expand their *cultural knowledge*. Providers acquire *cultural skills* as they learn how to collect subjective information and social histories as well as conduct physical assessments that are relevant to different cultures. The increased opportunity for *cultural encounters* through directly interacting with individuals and families from diverse groups helps providers to have practical experience with cultural norms and variations as well as language needs. At the intersection of awareness, knowledge, skills, and encounters is cultural desire. When providers want to learn and grow in the process of cultural competency and do not feel obligated to care for diverse cultures, then they expand their *cultural desire*. Throughout these processes, providers recognize the continuous process of learning.

As clinicians use these models and work with new cultures and in new environments, they may feel that they regress and are not as competent. However, if organizations and clinicians recognize that they are on a path of continuous improvement and approach the care of patients and communities with an attitude of humility and sensitivity to potential opportunities and barriers in care, they will be taking great strides toward providing a positive healthcare environment for their patients and the communities they serve.

LEGAL, REGULATORY, AND ACCREDITATION REQUIREMENTS

4 Legal and regulatory issues surrounding cultural competency include understanding and interpreting Title VI of the Civil Rights Act and accreditation standards for healthcare organizations. Title VI "prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance."[43,44] In 2000, under Executive Order 13166 of Title VI, federal agencies were required to evaluate and develop services for persons with LEP and meaningful access to these services.[44,45]

The 2013 enhanced National CLAS Standards (Culturally and Linguistically Appropriate Services) provide a framework for health and healthcare organizations to promote health equity and quality for diverse populations.[46] The Standards open with an overarching principle to "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." Fourteen additional standards grouped in three themes provide further guidance, including: (a) Governance, Leadership, and Workforce (Standards 2-4); (b) Communication and Language Assistance (Standards 5-8); and (c)

Engagement, Continuous Improvement, and Accountability (Standards 9-15). State and national policies have provided particular emphasis on access to language services including interpreters.[44,45] Standards 5 through 9 are federally mandated and must be offered and/or provided by agencies receiving federal funding (Table e3-2). Challenges persist to appropriately use, certify, and reimburse professional interpreters with a growing number of states also requiring cultural competency training for health professionals.

TABLE e3-2

Select Communication and Language Assistance Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare

Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all healthcare and services.
Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Data from Reference 44.

The Joint Commission (TJC), the primary national accrediting body for healthcare organizations and programs, supports CLAS standards through requirements for effective communication, cultural competence, and patient-oriented care.[47] This roadmap highlights the importance of integrating culturally competent care across the organizational and professional structure from patient admission to dismissal. Further, TJC has developed field guides to address care in the LGBT communities as well as evaluate safety based on the potential for implicit bias in healthcare.[48]

Improved patient safety occurs when providing appropriate language services and obtaining informed consent with well-translated and easily understandable forms. Thus, TJC has recommendations based on cultural and linguistic competency.[34,47] Considerations include collecting patient-level demographic data to report outcomes to better understand patterns in health disparities. HRSA has also developed indicators of cultural competence in healthcare organizations. The incorporation of cultural competency into TJC standards and HRSA guidelines gives organizations and healthcare leaders further rationale to move toward more culturally competent care.

TJC also emphasizes leadership involvement and ongoing staff education related to cultural competency. Further, more than 30 states in the United States have passed legislation requiring healthcare professionals to complete training in cultural competency or multiculturalism and/or have state-sponsored implementation activities.[46,49]

The healthcare system must work to engage patients and their communities.[5] There are definite trends from stakeholders in managed care, government, and academia to incorporate cultural competence for the purpose of improving quality of care and in some cases as a business imperative.[50] Independent of the legal and regulatory requirements, the ultimate goal of a healthcare provider is to improve patient outcomes including understanding the culture and language of patients.

PATIENT EXPLANATORY MODEL (PEM)

5 How do patients experience and understand their own health? According to medical sociologists, patients may enter the healthcare setting with a different explanation of their illness than the explanation found in the **WBM**. This model proposes that there is a pathophysiologic or etiologic reason for a disease. In many cultures, the source and meaning of illness may be attributed to a variety of other causes such as spiritual or religious influences or to retribution for previous deeds.[51] The term **disease**, from the view of Western medicine, is the result of a physiologic process. However, in most of the world cultures, the concept of **illness** is intimately related to the spiritual or religious aspects of their respective society. The clash of cultures can

sometimes cause confusion in the patient and/or the provider about the true effects of a treatment or illness. This conflict can cause unfortunate outcomes on many levels. To help identify cultural differences in a clinical setting, providers can ask patients questions to help elucidate the previous unforeseen differences.

One of the most studied and widely used clinical models is the PEM. It includes eight questions to evaluate a patient's explanation of disease (Table e3-3).[52] The model may best be used when clinicians sense discordance with the patient relating to adherence to a treatment plan or to the overall visit (see the Clinical Presentation box for an example of how to use the PEM).[53]

TABLE e3-3

Patient Explanatory Model—Eight Questions to Elicit Patient Understanding

1. **What** do you think has **caused** your problem?
2. **Why** do you think it **started** when it did?
3. **What** do you think your **sickness does to you**?
4. **How severe** is your sickness? Will it have a short or long course?
5. **What kind of treatment** do you think you should receive?
6. **What** are the most important **results** you hope to receive from this treatment?
7. **What** are the **chief problems** your sickness has caused for you?
8. **What** do you **fear** most about your sickness?

Data from Reference 52.

CLINICAL PRESENTATION

Using the Patient Explanatory Model Versus the Western Biomedical Model

A 55-year-old Latin American woman presents to the clinic for smoking cessation therapy. She reports smoking about 15 cigarettes a day, mostly when she is stressed and depressed. She lives in a rural, primarily Spanish-speaking community. Her education is limited to the fifth grade. In her home life, she is not able to make many financial decisions without permission from her husband.

When asked questions using Kleinman's PEM, the patient may have responded as follows (*assumptions/explanations according to the WBM are included for comparison*). Review of the possible responses to the questions provides a healthcare provider with insight about how a disconnect can occur with patients or their family members in developing a treatment plan.

1. **What do you think caused your problem (smoking)?**

   PEM: Well, my blood sugar is high because I smoke.

   WBM: The patient has come in for smoking cessation with no mention of diabetes.

2. **Why do you think it started when it did?**

   PEM: My mother was sick and she passed away about 10 years ago. I started smoking then because of the stress. Right after that, the doctor told me I had diabetes.

   WBM: Type 2 diabetes onset can begin with a number of risk factors including family history and obesity. Tobacco use is a dependence disorder.

3. **What do you think your sickness does to you?**

PEM: Smoking makes my blood sugar high. That's why I can't control my diabetes.

WBM: Smoking can affect diabetes, but it also can lead to heart disease, lung disease, cancer, and a number of other comorbidities.

4. **How severe is your sickness? Will it have a short or long course?**

   PEM: My diabetes will not go away unless I quit smoking.

   WBM: Diabetes will continue lifetime. Smoking cessation can occur, and if maintained, a person can continue tobacco free for the remainder of their lifetime.

5. **What kind of treatment do you think you should receive?**

   PEM: If I quit smoking, my diabetes will go away. I will use the patch and gum like you told me. I know I can't pay for the other medicines.

   WBM: To quit smoking, the patient may incorporate behavioral support with nicotine products. With depression, bupropion may also be indicated. The diabetes will require different medications as well as lifestyle support for diet and exercise.

6. **What are the most important results you hope to receive from this treatment?**

   PEM: That my diabetes will go away.

   WBM: That her general health will improve with smoking cessation. We can support improvement in her diabetes control.

7. **What are the chief problems her sickness has caused for her?**

   PEM: Smoking costs a lot of money, but I can buy cheaper cigarettes in Mexico. I am tired a lot.

   WBM: She may not feel the effects of smoking and may actually feel less anxious. However, lack of control of blood sugar can cause fatigue, frequent urination.

8. **What do you fear most about her sickness?**

   PEM: That I will die soon, like my mother.

   WBM: That smoking can lead to heart disease, lung disease, and cancer. The diabetes can also lead to negative health consequences and poor quality of life.

A modification of the PEM is the "4 Cs" (Call, Cause, Coping, Concerns), and this mnemonic device may be useful for providers.[14] Providers may ask the patient: (1) "What do you *call* the illness?" (2) "What do you think *caused* the disease or illness?" (3) "How do you *cope* with the disease or illness?" and (4) "What *concerns* do you have about your disease or illness?" This simplified version of Kleinman's original questions still provides information about how the patient interprets illness. However, use of the full explanatory model can provide more revealing information.

CULTURAL VALUES AND BELIEFS

6 Numerous factors can influence cultural values and beliefs toward healthcare as suggested by social determinants of health. Age, gender, race, ethnicity, sexual orientation, religion, geography, neighborhood, acculturation, and linguistic identities all shape how people behave and what they value. One of the dangers of learning to work with patients and families from different cultures is confusing stereotypes with generalizations. **Stereotypes** may be damaging to patients as they are an end point or assumption about the way people will behave.[14] **Generalizations**, however, can provide a framework or a beginning to understand how patients *may* respond in healthcare situations.[14] When developing a framework to work with patients, understanding the degree to which individuals identify themselves within different cultures is worthy of consideration.

Social Identity

One aspect of culture is linked to how social identity is defined. **Social identity** is a socially constructed characteristic shared by a group of people

which sets them apart from other groups.[54,55] Social group identities can be based on gender, gender identity, age, ethnicity, race, sexual orientation, religion, socioeconomic status, ability status, or other cultural factors. Individuals' social identities can either be classified as **agent, border, or target** based on cultural norms.[54,55] An **agent** is an individual who belongs to **social identity** groups that have ready access to resources resulting in social power and privilege.[54,55] Agent identity examples include heterosexual orientation, Christian religion, upper socioeconomic class, White race, and middle-aged adult. **Target identity groups** consist of individuals who are denied access to resources, resulting in less or no **social power**.[54,55] **Target** identity groups include people of color, lower class, homosexual orientation, youth, or older adults. **Border identity groups** may or may not have been privileged in the past, or who have privilege in some contexts and are **targeted** in other contexts.[54,55] Members of this group may be able to "pass" as members of the **agent** group. Examples include biracial individuals, those with a hidden disability and the middle socioeconomic class. An individual's social identities can influence their acceptance and hierarchical position as either superior or inferior according to societal and cultural norms.[54,55]

An individual's identification with a social group is influenced by contextual factors, such as individuals within the immediate environment.[56] For example, an African American woman may identify more strongly with her gender identity in the presence of several African American males but identify more strongly with her racial identity in the presence of several White women. In other words, there are instances in which one social group membership may become more salient and thus be more influential on behaviors than other group memberships. Understanding how strongly a patient identifies with a particular social group will assist healthcare providers in identifying the influence of that social group's cultural norms and expectations on the patient's healthcare decision making. For example, a patient who has recently immigrated must redefine how they identify with cultural groups or if they are considered target, agent, or border in the new context. This, in turn, defines how individuals experience the process of acculturation within dominant cultural groups in a new host country.

Acculturation

Culturally competent providers are familiar with the concept of acculturation and its role in the area of health. **Acculturation** can be defined as the process by which individuals from one cultural group experience changes in behaviors, attitudes, and beliefs as a result of continuous contact with a different culture.[56] Acculturation has been studied in relation to a number of health behaviors and its influence cannot be underestimated.[57]

Acculturation has been associated with a number of differences in health behaviors and perceptions of illness. For example, a patient may present with unique behaviors for willingness to use healthcare, adherence, attitudes toward healthcare providers and treatment, or beliefs about healing.[58] Some weaknesses in theories of acculturation (in studies conducted in the United States) exist because assumptions are made that immigrant populations are able to choose to participate fully in American society and that the ultimate goal is to assimilate into American culture.[12]

Regardless of how acculturation is measured or researched, understanding concepts related to acculturation can be helpful to providers. One model of acculturation that provides a framework for understanding acculturation describes assimilation, integration, marginalization, and separation as four possible outcomes of the acculturation process. In this framework, there are two cultures of reference, the home culture (the culture *from* which the individual comes) and the host culture (the culture *to* which the individual is introduced or is immersed).[57,59] This relationship can have varying levels of effect on each other and can be bidirectional in nature.

Individuals may have the least difficulty adapting to the new host culture when they are able to assimilate or integrate.[57,59] In **assimilation**, individuals lose (willingly or unwillingly) much of their identity from their home culture and adopt the new host culture. In **integration**, the individual is able to adopt identities from both the host and home culture. These individuals may be considered bicultural or even bilingual.

Through the process of marginalization and separation, individuals have a more difficult time adapting to a new host culture.[57,59] When individuals are **marginalized**, they have strong identities to their home culture and may not be able to adapt well to the host culture. Marginalized individuals may include more recent immigrants or refugees. Persons who are in **separation** may never really understand their home culture or their host culture. They may live "in between" cultures, never fully learning the home culture or host culture. This phenomenon may occur in children who have never completed their basic education in either culture (thereby never mastering one language) or who do not have enough exposure to cultural events and traditions from their home or host culture to entirely understand or appreciate either heritage.

As healthcare providers interact with patients, recognizing influences of acculturation can be helpful to understanding acceptance of prevention and

treatment options.

Individual Versus Collective Influences

There are other factors that influence how persons interact in cultures. For example, different cultures place varying emphasis on the importance of the individual and the collective influences on decision making.[60] Those persons who come from more **individualistic cultures** (eg, the United States) are more likely to place greater emphasis on an individual's self-reliance and emotional distance from others within the individual's group.[61] Patients from individualistic cultures expect greater individual responsibility for healthcare decisions.[62]

Alternatively, persons who come from **collective cultures** experience greater emphasis on interdependence and family integrity.[61] Patients from collectivist cultures experience increased community participation with their healthcare decision making.[63] Some cultural groups (eg, Latino, African American, and American Indian) may identify as being particularly **familistic**—the family unit has a core influence on their cultural and community identity.[64] A greater emphasis on the family unit leads to different attitudes and behaviors such as different expectations for seeking healthcare (eg, an aunt or godmother caring for the ill) and the development of different beliefs, norms, and traditions.[65]

Health Beliefs and Practices Found in Various Cultures

As healthcare providers work with patients from different cultures and backgrounds, they will discover healthcare beliefs and practices that are different from their own. Although it is not feasible to understand the intricacies of every culture, it is possible to explore common characteristics that are found in various cultures in order to learn more about them. Ultimately, **care should be individualized,** but **the following generalizations can serve as a guide to working with patients from different cultural backgrounds**. In some cases, clinicians can apply the mantra, "Treat others as *they* would want to be treated," also called the *Platinum Rule*.[58]

Individuals from different cultures may have different beliefs about the origins of health and illness and may not subscribe to the WBM.[38,52] Some cultures may view health as the result of harmony with nature or the balance of natural forces. Still others may believe that health is a result of good luck or reward for good behavior. Views about the origins of illness may also differ depending on culture. Some believe that illness is the result of an imbalance in natural forces while members of other cultures may point to supernatural powers as the cause of disease or illness. Various cultures describe illnesses that are only recognized within that culture. These "culture-bound syndromes," also often referred to as folk-illnesses, are often manifested through changes in behavior, cognition or affect without the presence of signs or symptoms that can be objectively confirmed.[14,66] There are a variety of culture-bound syndromes that have been documented. For example, conditions such as *empacho* (stomach pain caused by ball of food blocking the digestive tract), *susto* (illness arising from extreme fright), *mal de ojo* (illness caused by the "evil eye" resulting from excessive admiration or envy), or *caída de la mollera* (depression of anterior fontanelle in infant) can be found in Latin American cultures.[39,51] *Dhat* is a culture-bound syndrome reported in Indian cultures that manifests as fatigue, weakness, or sexual dysfunction thought to be caused by loss of semen during urination, masturbation, or nocturnal emission.[67] Culture-bound syndromes are also found in Western cultures. Anorexia nervosa, an eating disorder characterized by extreme weight-loss caused by self-starvation, is well-recognized in Western cultures but may not be acknowledged in other cultures.[68]

Certain healthcare practices may stem from historical events or experiences not explained by the WBM. For example, members of minority populations who have experienced racism, prejudices, and injustices, such as African Americans, may not trust the healthcare system or participate in research projects because of previous injustices, including slavery and the Tuskegee syphilis study.[69] The latter example refers to research conducted by the United States Public Health Service from 1932 to 1972, in which African American men with syphilis were recruited to participate in a study to investigate the natural course of untreated disease.[69] This project continued until the early 1970s despite the availability of penicillin and confirmation in the 1940s that penicillin was an effective treatment for syphilis.

It is important to recognize that members of various cultures may employ the use of traditional healers, CAM practices such as the use of herbs or other practices such as massage. Traditional healers who may be involved in the care of a patient include *curanderos(as)* in some Latin American cultures, "medicine men or women" in various American Indian communities, voodoo doctors by individuals practicing voodoo, or *santeros* (mediums) among individuals practicing *Santería* (a polytheistic religion based on beliefs and customs of the Yoruban people with incorporation of some elements of Catholicism).[39,51]

Furthermore, religious rituals or ceremonies are often an important part of treatment in many cultures. Some American Indian cultures, for example, may practice divination (diagnosis) or singing in the treatment of illness. Three types of divination include *motion in the hand* (pollen or sand is sprinkled around the patient while song is sung and diagnostician moves hand to determine the cause), *stargazing* (prayer to star spirit is made by stargazer and rays of light thrown by star are used to determine cause of illness), and *listening* (diagnostician listens for certain sounds to help in diagnosis). For some members of American Indian cultures, these practices may have a profound psychologic effect and allow the patient to feel cared for in a personal way.[51] Patients from various religious backgrounds may also include prayer as a way of coping with life stresses.[70]

Other culturally based healthcare practices may lead to physical signs on the body that might be taken as signs of injury or abuse. Patients of Asian descent may practice *coining* (coins are dipped in oil and heated and then rubbed on skin), *cupping* (heated glass cups are placed on the skin to create vacuum), *moxibustion* (heated incenses or wood applied over the skin) or pinching of skin in order to draw out illnesses. These practices may produce bruises, burns, or welts on the skin that might be confused with signs of physical abuse.[51] Clinicians should be aware that cultural beliefs may have led to the practice of alternative forms of healing and this should be taken into consideration when evaluating a patient.

Family roles and communication styles may also differ based on culture. Certain cultures have strong family values or close-knit family structures. As a result, the healthcare encounter with patients from these cultures may involve the participation of other members of the family. Communication styles will also vary; thus, clinicians should be aware of communication characteristics when working with patients of various cultures. Table e3-4 includes various characteristics related to healthcare beliefs, practices, and values that have been found in various racial and ethnic groups represented among the population of the United States.

TABLE e3-4

Examples of Cultural Beliefs, Values, and Practices

Various Beliefs on Health and Illness	• Health may result from harmony with nature; illness results from disharmony • Illnesses may be due to natural causes (God's plan, eating the wrong food, environmental) or unnatural causes (evil origins such as demons, spirits, "hexes," or the "evil eye") • Health may involve the balance of yin (cold) and yang (hot) or wet and dry; illness often caused by an imbalance • The human body may be divided into two halves—a positive and a negative energy pole, and the energy of the body can be controlled by spiritual means • A person's body may be viewed as a gift and should be cared for and well maintained • Illness is due to destiny, fate, or *karma* • Illness is due to punishment for sins from a higher being • Preference for cure as opposed to prevention
Healthcare Practices	• Time orientation may be focused on the "present" vs "future" and may impede preventive care and follow-up • Blood or organ donation may be rejected out of fear of hastening donor's death • May refer to certain foods as causing "high" or "low" blood, which may be confused with blood pressure or blood count • May use combination of Western medicine and traditional medicine • May be upset by the practice of drawing blood (source of life for the body that may not be regenerated) • Deep respect for the body may lead to refusal of painful procedures for diagnostic workups or surgery unless absolutely necessary • Cutting or shaving of hair should be discussed with patient as this practice may be associated with mourning in some cultures • Mental illness may be seen as a stigma and may prevent patients from seeking psychiatric care • Patient may wear items considered to be sacred (eg, threads, medallions, other religious items); permission to remove should be obtained when possible • Healthcare providers are often seen as authorities; patients may take a more passive role and prefer for a provider to make decisions

Complementary and Alternative Medicine (CAM) Use	• May use traditional or faith healers (eg, priests, magicians, voodoo doctors, medicine men/women, *curanderos/curanderas*) and/or religious rituals (eg, prayers, ceremonies, visiting shrines, making promises to God(s) or saints)
	• Folk medicine/traditional medicine/CAM may include
	  ○ Acupuncture
	  ○ Candles lit as a form of prayer or invoking God
	  ○ Coining, pinching, or cupping of skin to draw out illnesses
	  ○ Copper or silver bracelets or amulets to protect the wearer
	  ○ Massage
	  ○ Moxibustion
	  ○ Poultices to draw out infections
	  ○ Sweat baths or sweat lodges
	  ○ Use of herbs
	  ○ Use of "hot" or "cold" foods (based on the qualities of the food and not on temperature) may be recommended for certain conditions

Role of Family	• Families may be matriarchal or patriarchal ○ Women may defer to men for decision making in patriarchal families whereas women in matriarchal families are primary decision-makers • High esteem/respect for elders found in many cultures • Community/family may be viewed as more important than the individual • Family members may accompany patients to healthcare encounters and may want to be included in decision making and integrated into the treatment plan for the patient • In some cultures, family members may not permit discussion of serious healthcare issues directly with the patient
Communication Styles	• Some patients prefer to be addressed as "Mr." or "Mrs." or by professional title • Hand-gestures (eg, pointing, beckoning with index finger) may be insulting in some cultures • Some patients may avoid direct eye contact as a sign of respect • Developing and maintaining personal relationships and trust toward their healthcare providers may be important for patients • Patients may prefer same-gender providers due to modesty

Other resources for information on racial and ethnic groups include the following:

EthnoMed: http://ethnomed.org/

Lesbian, Gay, Bisexual and Transgender Health: http://www.cdc.gov/lgbthealth/

Migrant Clinician's Network: http://www.migrantclinician.org/

Refugee Health Information Network: https://refugeehealthta.org/2011/10/17/refugee-health-information-network/

Office of Minority Health, US Department of Health and Human Services: http://minorityhealth.hhs.gov/

Office on Women's Health, US Department of Health and Human Services: https://www.womenshealth.gov/

Data from References 14, 38, 51,71.

An additional aspect of culture is religion, which can influence health beliefs and practices across the lifespan. Patients and healthcare providers who

align with a religion or spiritual path may adapt their lifestyle to integrate unique diet and fasting, and many may avoid animal-based medicinal agents. Among various religions and practices, patients and providers may recite prayers and/or seek support from a spiritual leader as ways to honor their faith tradition and beliefs. Differing beliefs regarding contraception and family planning also exist across western and eastern religions. In some world religions, any form of contraception is unlawful while other religions have differing beliefs on prevention (eg, condoms, birth control pills), interruption (eg, Plan B), and abortion.[51,72] Table e3-5 lists some health beliefs and practices found in common worldwide religions.

TABLE e3-5

Healthcare Practices and Beliefs Found in Selected World Religions[a]

	Medications or Special Dietary Restrictions	Healing Practices
Buddhism	Vegetarian diet Some holy days require fasting	Prayer Picture of Buddha may be used to facilitate meditation
Christian Catholic	May use medications May avoid meat on Fridays during Lent	Prayer, candles, laying on of hands Holy sacraments may be offered to the sick Visits from priest
Christian Protestant	Varied restrictions and permission	Prayer Diverse opinions of divine intervention Visits from pastor Some beliefs prevent blood transfusions or organ transplant
Hinduism	Vegetarian diet; meat products often prohibited Several holy days require fasting Most medications permitted	Includes traditional Faith healing
Islam	Pork and alcohol often prohibited (may include medications that are pork-derived or that include alcohol) Meat preparation meets *halal* ("lawful") standards Fasting during Ramadan	Some herbal remedies and faith Visits from imam
Judaism	Pork and shellfish products often forbidden (may include medications or supplements that are pork- or shellfish-derived) Meat preparation meets Kosher standards Fasting during Yom Kippur (day of atonement)	Prayer Visits from rabbi

[a]These practices and beliefs may be found among persons (not all) who identify with the religions listed.

Data from References 51,72.

To illustrate some of these differences, consider the following examples.[51] A patient who comes from the Jewish or Muslim faith may be unwilling to

accept omega-3 fatty acids as a therapy option for hypertriglyceridemia because the gelatin formulation may not adhere to the dietary restrictions of the religions. A female patient whose religion embraces greater physical distance between women and men in social situations may not be comfortable working with a male healthcare provider. A devout Christian family may be concerned about discussions of contraception or emergency contraception.

To better elicit information about a patient's religious or spiritual concerns, providers may ask the following during the patient encounter: ***"I feel that I can help you better if you can tell me what religious or spiritual needs I should consider in your healthcare."***

UNDERSTANDING AND WORKING WITH THE LGBTQIA+ COMMUNITY

To understand the disparities that affect members of the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) populations, it is imperative to first master understanding of the unique identities that are encompassed under the LGBTQIA+ acronym umbrella. While a single acronym may suggest a cohesion of concepts and identities, the people that comprise the LGBTQIA+ communities are heterogeneous. The groups have a variety of beliefs, identities, and understandings, but all are bound by common experiences of stigma and discrimination.[73]

Furthermore, mastery of vocabulary related to how individuals within the LGBTQIA+ community identify is of utmost importance. Sexual orientation describes a person's sexual or emotional attraction to others, whereas gender identity is an intrinsic sense of being a woman, man, neither, or something else. For example, identifying as a lesbian, gay, or bisexual describes sexual orientation. Identifying as transgender refers to a person's gender identity; transgender people may be straight, gay, or bisexual. Gender expression is defined as the way a person communicates their gender to the world through mannerisms, clothing, speech, behavior, or in other ways, and these may or may not align with their gender identity or assigned sex at birth.[74] Table e3-6 includes a summary of definitions related to the LGBTQIA+ population.

TABLE e3-6

Select Definitions Related to the LGBTQIA+ Population

Term	Definition
Asexual (adjective)	"Describes a person who experiences little or no sexual attraction to others. Asexual people may still engage in sexual activity."
Bisexual (adjective)	"A sexual orientation that describes a person who is emotionally and physically attracted to women/females and men/males. Some people define bisexuality as attraction to all genders."
Cisgender (adjective)	"A person whose gender identity is consistent in a traditional sense with their sex assigned at birth; for example, a person assigned female sex at birth whose gender identity is woman/female."
Gay (adjective)	"A sexual orientation describing people who are primarily emotionally and physically attracted to people of the same sex and/or gender as themselves. Commonly used to describe men who are primarily attracted to men, but can also describe women attracted to women."
Gender binary structure (noun)	"The idea that there are only two genders (girl/woman and boy/man), and that a person must strictly fit into one category or the other."
Gender-diverse (adjective)	"Gender-diverse describes people whose gender identity falls outside traditional ideas of male or female. Some gender-diverse people feel like a mix of more than one gender; some feel more like one gender some of the time, and a gender that is something else at other times. A gender-diverse person may feel like both genders sometimes, and sometimes no gender at all."
Gender Expression (noun)	"The way a person communicates their gender to the world through mannerisms, clothing, speech, behavior, etc. Gender expression varies depending on culture, context, and historical period."

Gender Identity (noun)	"A person's inner sense of being a girl/woman/female, boy/man/male, something else, or having no gender."
Intersex (adjective)	"Describes a group of congenital conditions in which the reproductive organs, genitals, and/or other sexual anatomy do not develop according to traditional expectations for females or males. Intersex can also be used as an identity term for someone with one of these conditions."
Lesbian (adjective, noun)	"A sexual orientation that describes a woman who is primarily emotionally and physically attracted to other women."
Nonbinary (adjective)	"Describes a person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man."
Pansexual (adjective)	"A sexual orientation that describes a person who is emotionally and physically attracted to people of all gender identities, or whose attractions are not related to other people's gender."
Queer (adjective)	"An umbrella term describing people who think of their sexual orientation or gender identity as outside of societal norms. Some people view the term queer as more fluid and inclusive than traditional categories for sexual orientation and gender identity. Although queer was historically used as a slur, it has been reclaimed by many as a term of empowerment. Nonetheless, some still find the term offensive."
Sexual Orientation (noun)	"How a person characterizes his/her emotional and sexual attraction to others."
Transgender (adjective)	"Describes a person whose gender identity and sex assigned at birth do not correspond based on traditional expectations; for example, a person assigned female sex at birth who identifies as a man; or a person assigned male sex at birth who identifies as a woman. Transgender can also include people with gender identities outside the girl/woman and boy/man gender binary structure; for example, people who are gender fluid or non-binary. Sometimes abbreviated as trans."

Data from Reference 74.

Social Determinants of Health and Health Disparities in the LGBTQIA+ Population

Members of the LGBTQIA+ population face unique challenges, many of which are shaped and propagated by an extensive history of oppression and discrimination. There are many complex social determinants of health that mold the experiences of members of the LGBTQIA+ community and transcend all ages, races and ethnicities, religions, identities, and social classes. These determinants of health stem from many places, including the legality of discrimination in access to health insurance, employment, housing, marriage, child adoption, and retirement benefits, the lack of anti-bullying laws, and a shortage of health care providers who are culturally competent and knowledgeable in LGBTQIA+-specific health matters.[75] Additionally, there is a lack of social programs aimed at addressing many of the issues faced by various subpopulations of the LGBTQIA+ community.[75]

The social determinants of health described above have led to many disparities within the LGBTQIA+ population, especially related to accessing, navigating, and thriving in the healthcare system. With regard to access, members of same-sex relationships are significantly less likely to have health insurance and report higher rates of unmet health needs.[73]

There are several examples of identified health disparities among members of the LGBTQIA+ population as well. For example, men who have sex with men (MSM) and transgender persons have a greater risk of HIV and other sexually transmitted infections, with even greater disparities demonstrated in LGBTQIA+ communities of color.[73,75] Rates of human papillomavirus–associated anal cancers in MSM are 17 times greater than heterosexual male

counterparts.[73] LGBT populations have the highest rates of tobacco, alcohol, and other drug use.[75] Additionally, studies have suggested that gay, lesbian, and bisexual people have higher rates of depression, anxiety, and suicidal ideation, and LGBT youth are 2 to 3 times more likely to attempt suicide.[73,75] More specifically, members of the transgender community have a high prevalence of mental health issues, risk of suicide, and violence and victimization.[75]

While there are many players in the development and propagation of these social determinants of health, the creation of uniform guidance has created a unified approach to tackling many of these issues.

Strategies for Overcoming Barriers and Creating Inclusive Environments for LGBTQIA+ Patients

Discrimination toward LGBTQIA+ people is common in healthcare settings, and this can lead to fear of a negative experience or avoidance of the health system altogether. There are a few strategies that can be employed to ensure that LGBTQIA+ people receive the quality, inclusive, and affirming care that they deserve.

Creating and Revising Organizational Policies

The creation or revision of nondiscrimination policies to include gender identity, gender expression, and sexual orientation should be completed to protect LGBTQIA+ people in the workplace. Policies that allow transgender and gender-diverse people to use the bathroom that align with their gender identity should also be created if those do not already exist. Any created policies should be posted visibly and clearly in physical and virtual locations.[76]

Communication

Improving communication with LGBTQIA+ patients requires training at all levels of an organization and should encompass many areas relevant to the LGBTQIA+ population, including behavioral health, sexual and reproductive health, transgender and gender-diverse clinical care, and HIV prevention and treatment.[76]

Gender-assuming language such as “Ms.,” “Mr.,” “Sir,” or “Ma’am,” should be avoided when a patient’s pronouns are not known. Referring to the patient by their name or saying, “The patient is in the waiting room,” avoids assuming gender and is more inclusive.[77] Table e3-7 includes a list of outdated and insensitive terms that should be avoided and provides recommended terms that are more appropriate and inclusive.

TABLE e3-7

Examples of Outdated Versus Recommended Terms When Working with Members of the LGBTQIA+ Communities

Outdated Term	Recommended Term
Biological female/male	Assigned female/male at birth
Hormone replacement therapy	Gender-affirming hormone therapy
Female-to-male (FTM) and male-to-female (MTF)	Transgender man and transgender woman
Preferred name	Chosen name or name used
Preferred pronouns	Pronouns
Sex change, sex reassignment surgery, gender reconstruction surgery	Gender-affirming surgery
Sexual preference/lifestyle	Sexual orientation
Transgendered	Transgender

Data from Reference 74.

Respectful and inclusive communication is especially important when working with transgender and gender-diverse (TGD) people. Many TGD people may have a different chosen name from the name on their identification documents, and their pronouns may also be changed and/or unfamiliar.[77]

Recommended strategies regarding use of pronouns:

- If a person's pronouns are not clearly known or documented, it is important to clarify by asking, *"How would you like to be addressed?"* or *"What name do you go by and what are your pronouns?"*
- If a mistake is made and the wrong pronouns used, a succinct apology and correction can be effective in conveying honesty and openness to learning. *"I apologize. I am still learning. Let me try again,"* is an example of how to effectively correct a mistake.
- Finally, staff should be trained to understand and rectify any discrepancies that may occur as a result of different chosen names/pronouns from those in the medical record. Questions such as, *"Could your chart be under a different name?"* or, *"What is the name on your insurance?"* can be useful in handling clerical issues while sparing any embarrassment or disrespect to the patient.

Collection of Data

Many state and national surveys do not collect population-level data on sexual orientation and gender identity (SOGI), which is imperative to help inform effective health promotion strategies as well as produce nationally representative information about the LGBTQIA+ populations.[75,78]

Registration and electronic health records should have standardized SOGI demographic questions to monitor and improve the care process. Collection of patient pronouns can be useful to improve communication among medical staff.[76] Forms used should be evaluated for inclusivity related to relationship status, gender identity, and sexual orientation. For example, instead of "marital status," the use of "relationship status" is more appropriate when collecting demographic information.

Recruitment and Representation

Those responsible for hiring decisions, including those within healthcare organizations, should strive to hire a diverse workforce that represents the

LGBTQIA+ communities. Medical staff should be proficient in LGBTQIA+ health and/or demonstrate an interest in gaining the necessary knowledge and skills to provide inclusive care.[77]

CROSS-CULTURAL COMMUNICATION

7 Developing communication skills to interact with diverse populations includes recognizing personal styles of communication. However, providers should have communication skills to recognize if a barrier may exist, and they should work to care for patients regardless of the language they speak. Understanding personal communication styles provides insight to clinicians so they may be able to prevent or acknowledge any bias or expectations during clinical encounters. By recognizing personal cultural biases, clinicians can better serve the patients.

Barriers related to cross-cultural communication can affect the provider-patient relationship. From the perspective of the Joint Commission, the threat to effective communication is threefold: language differences, cultural differences, and low literacy levels.[47,79] Patients can also have communication barriers because of differences in age or gender with the provider.[8] A person with a lower level of education may not be comfortable working with a provider who has obtained a college education and/or attended graduate school. An older patient may not believe that a younger provider has enough work or life experience to be qualified. A man from a more conservative religious upbringing may not feel it is appropriate to be counseled by a female provider. Other barriers to care may exist because of fear and distrust in the provider due to race or ethnic background, prejudices, or lack of familiarity or knowledge of the culture.[8,53] For example, a patient who is of Chinese descent may not feel comfortable with a provider who is Mexican American because of a perception of unfamiliarity and a lack of opportunity to interact with persons of the other background.

Communication Skills

Communication skills needed to work with patients from diverse cultures include looking for nonverbal cues.[8,51,53] Providers can often gain clues for how to interact with patients by observing their behaviors and following patients' mannerisms. Patients will have varying preferences of eye contact, personal space, and physical contact.[8,51] Some patients prefer indirect eye contact and may view direct eye contact as rude or intrusive. A comfortable distance for personal space also varies across cultures.[8,53,80] In some cultures, patients prefer only a handshake or a nod of acknowledgment for greetings, whereas in other cultures, patients will welcome a light tap on the shoulder or even a hug.

Verbal cues include recognizing whether patients prefer to be called using their first name or last name.[8,14,51] Some patients embrace the opportunity to talk and get to know their provider before jumping into medical information. Using a vocabulary that is consistent with the culture and education of patients is another strategy that can help providers gain trust.

To develop skill sets to work with patients from diverse communities, providers can identify cultural "brokers" or community liaisons.[15] These liaisons are often respected community members and leaders who recognize the importance of connecting the healthcare community with the community being served. Liaisons may be religious leaders or mothers and grandmothers in the community. The key is to align providers with these community liaisons to help interpret what cues (nonverbal and verbal) and ways of communicating are most appropriate.

LEP and Hearing Impairment

According to Census data, nearly 22% of people living in the United States who are 5 years of age and older speak a language other than English in the home.[16] LEP occurs when a person is not able to communicate effectively (reading, speaking, writing, or understanding) in the English language because of English not being the primary language.[81,82]

8 Linguistic competency encompasses understanding issues related to working with patients with LEP and/or hearing impairments such as learning basic terms and greetings, working with an interpreter or language-assistance lines, and using non-English patient education/materials.

For healthcare providers to more effectively communicate information to patients with LEP, it is important to identify the most common languages spoken among their patients. As outlined in the CLAS standards, organizations receiving federal funds (indirect or direct) must provide meaningful access to persons with LEP.[44,81,82] Using professionally trained interpreters improve clinical care, improve patient safety, and increase satisfaction for patients with LEP.[83-86] In addition to having qualified interpreters, it is important to train healthcare providers to use and interface with professional

phone interpreter services.[87] A variety of online resources are available to begin learning about working with interpreters and translators (Table e3-8).

TABLE e3-8

Resources for Working with Interpreters and Translators

Tips for Working with Healthcare Interpreters: https://refugeehealthta.org/access-to-care/language-access/best-practices-communicating-through-an-interpreter/
Tips for Working with Sign Language Interpreters: www.ncdhhs.gov/document/tips-working-sign-language-interpreters
Sight Translation and Written Translation: Guidelines for Healthcare Interpreters. The National Council on Interpreting in Health Care www.ncihc.org/assets/documents/publications/Translation_Guidelines_for_Interpreters_FINAL042709.pdf

While interpreter services may exist, challenges persist to identify patients with language assistance needs as well as to maintain a consistent and qualified language assistance workforce in the healthcare system.[88] If a trained interpreter is not available, the clinician may need to work with an ad hoc interpreter (eg, bilingual coworker, family member, and friend), which poses a greater risk for error.[53] Children (minors) should not be used as interpreters. Clinicians should be actively aware of the interpretation situation. If the interpretation is muddled or the process seems confusing, then it is appropriate to insist upon finding a more reliable source of interpretation.

Organizations and clinicians can also create a positive environment for patients with LEP by having written materials translated into the common languages found in the served population. Materials should be translated by certified translators and not by staff members, family, or friends who state that they are bilingual.

Tools for Working Across Cultures

Clinicians should recognize that assessing culture in the patient encounter is not necessarily a new concept.[53] The "social history" of patients provides room to explore the patient's individual and family situation, work and home environment, unique dietary needs, and education background, among other sociocultural influences. 9 Fortunately, tools have been developed to help providers further address unique cultural situations that can arise in the patient encounter.

One model frequently cited for working with patients from diverse cultures is LEARN (listen, explain/empathize, acknowledge, recommend/respect, and negotiate).[80] In the LEARN model, providers are called to ***listen*** to their patients' perceptions of their health with an open mind. Providers should then take time to ***explain*** their perceptions and ***empathize*** with the patient. ***Acknowledgment*** of commonalities and differences in the approach to understanding health and treatment options for the patient can help to build trust. When providers ***recommend*** a treatment plan in a way that is ***respectful*** of the patient's culture and beliefs, the provider and patient can find a common ground. With this baseline respect, a plan can be ***negotiated*** to ***navigate*** through the healthcare system.

While barriers do exist for cross-cultural communication, clinicians can overcome these challenges by understanding verbal and nonverbal cues to communication. They also should recognize that quality interpretation is essential in the patient encounter. Tools for navigating across cultures include learning how to listen, empathize, and negotiate a treatment plan with patients.

ORGANIZATIONAL AND INDIVIDUAL SELF-ASSESSMENT

10 Both individuals and organizations demonstrate the capacity for providing a culturally competent environment. Before understanding other cultures, *individual practitioners* should understand their own personal values and beliefs. Additionally, assessment of attitudes, practices, policies, and structures *within an organization* can assist in planning for and incorporating cultural competence into the provision of healthcare within

organizations.[89,90]

The process of self-evaluation may begin with the simple act of a practitioner reflecting on the values and beliefs that shape their world view, their perceptions of health and illness, and the existence of stereotypes or myths about other cultures.[15] To assist in this process, self-assessment instruments have been developed to guide individual healthcare providers in their reflection of cultures, values, and beliefs.

A variety of assessment tools designed for use by individual practitioners are available in both written and online formats (Table e3-9 provides recommended Websites that have links to various cultural competency assessments). Domains that are typically assessed by these instruments include values and belief systems, communication styles, experience in cultural diversity, materials and resource evaluations, and others. Many of these tools pose specific examples or questions within each domain that allow practitioners to assign ratings that reflect their level of cultural competence. Although there are no correct answers, these instruments provide individuals the opportunity to identify personal attitudes, values, and beliefs that do not foster cultural competence. By becoming aware of these issues, the practitioner may then make plans to improve upon or change these characteristics and move toward a more culturally competent approach to providing healthcare.

TABLE e3-9

Recommended Websites for Cultural Competency Assessments

National Center for Cultural Competence (NCCC): Self-Assessments https://nccc.georgetown.edu/assessments/ Transcultural C.A.R.E. Associates: Cultural Assessment Tools http://transculturalcare.net/cultural-assessment-tools/

Data from References 89,90.

The assessment of the cultural competence of organizations and systems is just as important as individual assessments and should not be overlooked. Assessing the cultural competency of an organization promotes the principles of equal access and the provision of services in a nondiscriminatory manner.[2] To plan for and incorporate cultural competence into an organization, attitudes, policies, practices, and structure within the organization should be considered. An essential part of this assessment involves determining the needs, preferences, and satisfaction of patients and consumers who are served by the organization. Tools that may be used by organizations to assess cultural competence are also available from links included in the accompanying table (see Table e3-9). Additionally, steps for planning and implementing an organizational self-assessment are summarized in Table e3-10.

TABLE e3-10

Steps for Planning and Implementing Organizational Self-Assessment

1. Cultivate leadership among members of the organization to promote self-assessment. 2. Get “buy-in” from personnel, consumers, and communities. 3. Ensure community collaborations and partnerships. 4. Build support for the process by creating a committee, work group, or task force with responsibility for overseeing the self-assessment process. 5. Allocate personnel and fiscal resources. 6. Manage logistics. 7. Analyze and disseminate data. 8. Take the next step to establish organizational priorities and develop a strategic plan with goals and objectives.

Data from Reference 90.

Regardless of which tool is used, an assessment of cultural competency should be conducted periodically on an ongoing, long-term basis.[89]

Individuals and organizations are on a cultural-competency continuum at all times, with varying levels of awareness, knowledge, and skills. Periodic use of these tools can help individuals and organizations identify in which direction they are moving on the continuum in order to make necessary adjustments.[91]

Engaging in assessments of cultural competency can result in several benefits to the individual practitioner or organization.[89] One benefit includes the ability to determine whether providers or healthcare organizations are meeting the needs of the patients being served. Additionally, the process can improve patient and customer satisfaction, and allow for the identification of strengths that the individual practitioner or organization has to offer. Ultimately, conducting assessments allows for the recognition of opportunities for growth and improvement to create a healthcare environment that can achieve better patient outcomes.

CONCLUSION

A diverse society will yield diverse health beliefs and practices. The influence of culture on healthcare encompasses understanding social determinants of health and how environments and community networks help shape the health of individuals and families. The United States—with its culturally diverse society and health disparities, patient-safety concerns, and workforce shortages—has unique opportunities and challenges in patient care. To work in this environment, clinicians should understand legal and regulatory issues related to cultural and linguistic competency. To excel in diverse patient care, providers need the knowledge and skills to elicit patients' explanation of their health status, recognize potential cultural influences on healthcare beliefs and practices, and communicate effectively with patients from different languages and cultures. Individual and organizational self-assessments can reveal helpful information about attitudes, values, and capacity to provide culturally and linguistically responsive services to patients and communities. The ability for providers and organizations to navigate well in a diverse population can help to create a safer and more equitable healthcare environment for patients to receive care.

ABBREVIATIONS

CAM	complementary and alternative medicine
CLAS	culturally and linguistically appropriate services
HRSA	Health Resources and Services Administration
LEARN	listen, explain/empathize, acknowledge, recommend/respect, and negotiate
LEP	limited English proficiency
LGBT	lesbian, gay, bisexual, transgender
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, asexual
MSM	men who have sex with men
PEM	patient explanatory model
SOGI	sexual orientation and gender identity
TJC	the joint commission
TGD	transgender and gender diverse
WBM	western biomedical model
WHO	World Health Organization

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SELF-ASSESSMENT QUESTIONS

1. Which of the following is a compelling reason for healthcare providers to strive toward cultural competency and promoting diversity in healthcare?

   A. Health disparities are declining and are no longer relevant.

   B. The diversity of patients encountered in the United States has plateaued.

   C. Health professional shortages are no longer a concern.

D. Medication errors can be reduced by improving linguistic competency.

2. Social determinants of health are factors that affect the quality of life, functioning, and health of individuals. All of the following are examples of social determinants of health *except*?

   A. Neighborhood and built environment

   B. Genetic makeup

   C. Economic stability

   D. Access to high-quality education

3. Based on the cultural competency models addressed in this chapter, which of the following statements is *true*?

   A. The LEARN model describes providers as going through distinct stages of change ranging from cultural destructiveness to cultural proficiency.

   B. Cultural competency is achieved through experience, skills, knowledge, and a positive attitude.

   C. The Purnell model describes providers as progressing through a continuum of cultural consciousness ranging from the unconsciously incompetent to the unconsciously competent.

   D. Cultural humility plays a minor role in connecting the skills, encounters, and desire to work across cultures.

4. According to the 2000 Executive Order 13166 of Title VI of the Civil Rights Act, which of the following services should a healthcare organization meet to receive federal funding (eg, Medicare)?

   A. Recruit, retain, and promote a diverse staff and leadership representative of the service area demographics

   B. Offer and provide meaningful access to language services at a nominal cost to patients with limited English proficiency

   C. Make easy-to-understand printed materials available in languages used frequently in the population served

   D. Using family or minors as interpreters may be used if requested by the patient

5. The Patient Explanatory Model includes which of the following?

   A. Explaining the pathophysiologic process of diseases

   B. Identifying potential causes of illness

   C. Involving the family and community in deciding the treatment for a patient

   D. Navigating between spiritual and family leaders to help the patient improve

6. The “4 C’s” is a simple method to elicit patients’ understanding of their health and illnesses. Which of the following is an example of one of the questions that is asked of patients in this model?

   A. “What do you think will cure your condition?”

   B. “When did you complete your last course of medication therapy?”

   C. “What will the problem cost you?”

   D. “What concerns do you have about your health condition?”

7. When striving toward cultural competency, which of the following statements about stereotypes, generalizations, and patient care is *true*?

A. Generalizations can help to provide a framework for understanding how patients may respond to a health-related situation.

B. Stereotypes can help to form reasonable assumptions about how patients from different cultures will behave in the healthcare setting.

C. Stereotypes and generalizations can be helpful in creating a positive healthcare environment.

D. Stereotypes and generalizations are not useful in understanding how a patient may react in a healthcare setting.

8. Each of the following statements are true regarding diverse healthcare beliefs or practices that are found in various racial and ethnic groups in the United States *except*?

A. Female patients from patriarchal families may defer to male family members for decision-making.

B. Trust in the US healthcare system exists because of previous efforts for equality (eg, Tuskegee syphilis study)

C. Patients may use traditional or faith healers to help them address health concerns

D. Avoidance of direct eye contact may be seen as a sign of respect

9. Which of the following is considered an outdated and/or insensitive term?

A. Preferred pronouns

B. Sexual orientation

C. Assigned male at birth

D. Chosen name

10. Effective strategies for overcoming barriers and creating inclusive environments for LGBTQIA+ patients include which of the following?

A. Creating or revising nondiscrimination policies for sexual orientation only

B. Assigning transgender and gender-diverse patients to another provider when chosen names or pronouns are incorrectly used

C. Avoiding use of gender-assuming language such as “Ms.” or “Mr.”

D. Encouraging medical staff to be proficient in LGBTQIA+ care after caring for a member of the LGBTQIA+ community

11. Which of the following is an example of a social determinant of health that affects the LGBTQIA+ community?

A. Legal discrimination in accessing health insurance, employment, housing, marriage, adoption, and retirement benefits

B. Abundance of social programs targeted toward the LGBTQIA+ community

C. Existence of extensive anti-bullying laws

D. Surplus of culturally competent and knowledgeable healthcare providers

12. Examples of communication styles that work across cultures include:

A. Shaking hands as a form of respect

B. Providing ample distance to show respect of interpersonal space

C. Using the first name to address a patient

D. Observing patient behaviors and trying to follow them

13. Of the following choices, the most appropriate way to determine how to communicate with a patient from a different culture and language than your own is to:

    A. Provide as much information as possible to demonstrate professional competency

    B. Use a variety of written resources about the culture of the patient before the visit and use only this information to conclude your treatment approach

    C. Talk to the bilingual staff members and ask how they would want to be treated

    D. Treat the patient as they would want to be treated and use a trained interpreter

14. If you do not speak the same language as your patients, what would be the optimal way to conduct the patient visit?

    A. Use a family member to interpret

    B. Ask a bilingual staff person to interpret for you

    C. Use a trained interpreter

    D. All of the above

15. Assessment of organizational values and beliefs about diversity and culture are important for providing a positive and open environment for patient care and should be conducted:

    A. When an organization is expecting an accreditation or licensure survey.

    B. On an as-needed basis for performance improvement.

    C. If patient satisfaction surveys reveal poor outcomes.

    D. Periodically with long-term considerations for the organization.

SELF-ASSESSMENT QUESTION-ANSWERS

1. **D.** Changes in demographics, the existence of health disparities, the need to promote patient safety, and persisting healthcare workforce shortages are among the reasons for needing cultural and linguistic competency skills and promoting diversity and equity in healthcare. Thus, Answer Choices A-C are incorrect. Answer Choice D is an example of how patient safety can be improved by striving toward cultural competency and promoting diversity in healthcare.

2. **B.** Social determinants of health include factors related to the places where people live, work, worship, or play as well as the structural environments within which they live (see Fig. e3-1). They include neighborhood and built environments (Answer Choice A), economic stability (Answer Choice C), education access and quality (Answer Choice D), as well as healthcare access and quality, and social and community context. A person's genetic makeup is largely non-modifiable and is not considered a social determinant of health; thus, Answer Choice B is correct.

3. **C.** Answer Choice C most accurately represents the correct description of one of the cultural competency models described (see Cultural Competency Models section of Chapter e3). The LEARN model is not a cultural competency model, rather it is a tool to foster cross-cultural communication between providers and patients (Answer Choice A is not correct). The models described in this chapter highlight that cultural competency is something that is not achieved; rather, it is a process that one can engage in and work toward (Answer Choice B is not correct). Cultural humility is an important part of developing cultural competency skills to work across cultures (Answer Choice D is not correct).

4. **C.** Executive Order 13166 of Title VI (2000) stipulates that federal agencies are required to evaluate and develop services for persons with limited English proficiency (LEP) and provide meaningful access to these services. Thus, Answer Choice C is correct in that it is one example of how services are made available to persons with LEP (see Standard 8 in Table e3-2). Although similar, Answer Choice B is incorrect since services for persons with LEP are not to be provided at an additional cost to the patient (see Standard 5 in Table e3-2). The other incorrect answer choices (A, D) are not

mandated by this Executive Order. Refer to the Limited English Proficiency and Hearing Impairment section of this chapter to read more on the use of family members as interpreters in the absence of trained, professional interpreter.

5. **B.** The Patient Explanatory Model (PEM) is a model that can be used to evaluate a patient's explanation of their disease (see Table e3-3). Thus, it can help the patient identify what they think are the potential causes of their illness (Answer Choice B is correct). The Western Biomedical Model is one that is used to explain the pathophysiologic process of disease (Answer Choice A is not correct). Answer Choices C and D are tools that can be used in providing cross-cultural care, but they are not specific components of the Patient Explanatory Model.

6. **D.** A modification of the Patient Explanatory Model is the "4 C's" (Call, Cause, Coping, Concerns), and this mnemonic device may be useful for providers. Providers may ask the patient: (1) "What do you **call** the illness?"; (2) "What do you think **caused** the disease or illness?"; (3) "How do you **cope** with the disease or illness?"; and (4) "What **concerns** do you have about your disease or illness?" Answer Choices A, B, and C are not elements of the 4 C's.

7. **A.** While generalizations may be helpful in providing a framework for how patients may respond based on their cultural background, stereotypes should be avoided since they can be damaging to patients as they are assumptions about how someone will behave (Answer Choices B, C, and D are incorrect). This is discussed further in the Cultural Values and Beliefs section of this chapter.

8. **B.** A variety of health beliefs and practices are observed from people across racial and ethnic groups (see Tables e3-4 and e3-5). Choices A, C and D are examples of health beliefs or practices that may be encountered among the population of the United States. Unfortunately, a lack of trust in the healthcare system does exist for some members of minority groups due to previous injustices such as the Tuskegee syphilis study (Answer Choice B is correct).

9. **A.** There are many previously used terms that are now outdated and/or insensitive. Answer Choice A is correct because the term "preferred pronouns" implies that using a person's pronouns is optional. The same concept applies to Answer Choice D, as "chosen name" should be used instead of "preferred name." Answer Choices B and C are incorrect because "sexual orientation" is preferred over "sexual preference/lifestyle" and "assigned male at birth" replaced the outdated term "biological male". Refer to Table e3-7 for more information.

10. **C.** Many times, a patient's pronouns may not be known and the use of gender-assuming language does not create an inclusive environment. Referring to the patient by their name or as "the patient" avoids any assumptions. Answer Choice A is incorrect because non-discrimination policies should include gender identity, gender expression, as well as sexual orientation. If a mistake regarding a patient's chosen name or pronouns is made, a succinct apology and correction would be an appropriate response, making Answer Choice B incorrect. Answer Choice D is incorrect because all members of the medical staff should be proficient in LGBTQIA+ health regardless of previous experiences in caring for a member of the LGBTQIA+ community.

11. **A.** Answer Choice A is correct because legal discrimination against the LGBTQIA+ community is prevalent in various aspects of insurance, employment, and social programs. There are limited social programs targeted toward the LGBTQIA+ community, a lack of anti-bullying laws, and a shortage of culturally competent and knowledgeable healthcare providers, making Answer Choices B, C, and D incorrect.

12. **D.** Communication preferences vary widely across cultures. The examples provided in Answer Choices A, B, and C may be acceptable for some members of cultural groups but not others. Providers can gain clues for how to interact with patients by observing their behaviors and trying to follow their mannerisms (thus Answer Choice D is correct).

13. **D.** Although exploring information about various cultures can serve as a guide when working with patients from different backgrounds, care should be individualized. Clinicians can apply the mantra "treat others as they would want to be treated" (also known as the Platinum Rule as discussed in the Cultural Values and Beliefs section of Chapter e3). Thus, Answer Choice D is the best answer to this question.

14. **C.** It is preferred that professionally trained interpreters be used to communicate with patients who speak a different language (Answer Choice C is correct). Healthcare providers should train to use and interface with professional interpreter services. When a trained interpreter is not available, clinicians may need to work with an ad hoc interpreter (eg, a family member, another staff member who is bilingual). However, this does pose a risk for error. It is important to note that children (minors) should not be used as interpreters. For more information, refer to the Limited English Proficiency and Hearing Impairment section of Chapter e3.

15. **D.** Organizational assessments of cultural competency should be conducted periodically on an on-going, long-term basis (Answer Choice D is

correct). Answer Choices A, B, and C list opportunities for organizations to schedule self-assessment activities, but they should not be the only times that organizations engage in these self-assessments. Various assessment tools are available to assist both individuals and organizations (see Table e3-9).