

PERCEPTIONS OF CULTURAL COMPETENCY AMONG ELDERLY AFRICAN AMERICANS

We conducted a qualitative study of 23 subjects to determine how African Americans perceive culturally competent care by physicians. Our objectives were to understand patients' perceptions of: 1) high-quality health care by physicians; 2) the role of culture and ethnicity in the doctor-patient relationship; and 3) patients' expectations of doctors. We developed a discussion guide and a questionnaire to capture the perception of competent (desirable or high-quality) health care in the context of cultural beliefs and attitudes. We found that African Americans are concerned with traditional performance aspects of care. In addition to professional demeanor and appropriate diagnosis and treatment, communication and respect were critical aspects of the process of care. Most participants thought that physicians should know something about African American culture but only in the context of healthcare issues. For these individuals, a culturally competent doctor is one who provides effective treatment while showing respect and using effective communication methods, regardless of the ethnicity and sex of the doctor. Future research on cultural competence in the doctor-patient relationship must elicit the full range of patient values—technical performance, general (culture-non-specific) process of care, and cultural-specific preferences. (*Ethn Dis.* 2006;16:778–785)

Key Words: African Americans/Blacks, Aging, Health Professionals, Qualitative Research, Quality of Care

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INTRODUCTION

Multiple studies in recent years have shown disparities between access to and quality of care available to mainstream and minority groups in the United States.¹ Multiple factors contribute to these disparities: socioeconomic disadvantage, lifestyle issues and exposure to risk factors, limited education, inadequate insurance, inadequate access to high-quality health care, provider biases, and distinct cultural beliefs of individuals involved in healthcare decisions. The difficulty in understanding the effect of culture on health care is increased because these cultural interactions occur at the individual level of patient and health professional and at the level of the practice or health system.

Evaluations of culturally appropriate care are constrained by the variable terminology and references to the phenomenology of cultural competence. The Department of Health and Human Services refers to “healthcare services that are respectful of and responsive to cultural and linguistic needs.”² For some, cultural competence is grounded in one’s ability to transform understanding into interventions.³ Others have used cultural competence to refer to provider characteristics (eg, knowledge, attitudes, and behaviors)^{4,5} and to health systems (structure and staff of the organization, relationships with the community).⁶ Expounding on these two features of care, Betancourt et al identify three barriers to achieving cultural competence—organizational, which incorporates characteristics of the health system such as leadership and workforce diversity; structural, which refers to the quality of all aspects of the healthcare experience and accessibility to specific types of care; and

clinical, which describes the healthcare provider-patient relationship.⁷ The combination of all of these factors (eg, sensitivity, knowledge, skills) results in the capacity to deliver desirable care⁷ along with the actual delivery of high-quality care.^{4,8–10} However, the complexity of evaluation is increased when the term “cultural competence” applies to attitudes, knowledge, and skills of providers and to the structure and policies of health systems.^{1,3,5,7}

If investigators, policymakers, administrators, and educators are to measure cultural competence, the three areas of competence—organizational, structural, and clinical—should be disengaged, and investigators should obtain data from the perspective of the patient. Much of the research on the clinical component of cultural competence has pointed to the importance of making the patient part of the diagnosis and treatment processes. Kaplan et al¹² and Cooper-Patrick et al¹³ refer to this process as participatory decision-making. Other studies have found that trust and respect are also necessary components of effective cultural competence. In studying patient-physician racial concordance and patient satisfaction, Saha et al found that for African Americans the strongest association was whether their physician treated them with respect.¹⁴ Educational and theoretical research advises physicians that their patients’ perceptions of what is wrong, that is, the patient’s explanatory model of the illness, is just as important in affecting behavior as diagnosis.^{10,15–17}

While evidence of the prevalence of health disparities is documented most frequently and convincingly in African Americans, most of the attention to cultural competence has used examples

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of non-English speakers⁵ and recent immigrants to the United States.²⁰ Less striking than the cross-cultural differences between these groups and the mainstream culture may be the subtle differences observable among African Americans, for whom a greater degree of acculturation and a similarity of language exist. Additionally, the lack of trust consequent to social and historical relationships between the African American community and health providers may result in unique perspectives of African Americans. This study aimed to expand our understanding of cultural competence in the doctor-patient relationship from the viewpoint of African Americans by using qualitative methods to determine how African Americans perceive culturally competent care.

METHODS

Recruitment of Focus Group Participants

The sample consisted of 23 African American residents of West Philadelphia or Southwest Philadelphia, most of whom were 61–75 years of age, although five were somewhat younger and three were older. The sample met the three major demographic criteria: age (≥ 40 years), ethnicity (African

Table 1. Demographic summary of focus group participants

	Focus Group #1 N=11	Focus Group #2 N=12
Sex		
Females	8	9
Males	3	3
Residency in Philadelphia		
>21 years	9	12
Age		
40–60 years old	2	4
61–75 years old	8	6
≥ 76 years old	1	2
Income		
$\leq \$15,000$	7	3
\$15,001–\$25,000	2	4
\$25,001–\$35,000	1	1
\$35,001–\$50,000	1	4
Education (highest level completed)*		
<12th grade	2	0
12th grade	3	5
Some college	6	5
Post-college	0	1

* 1 did not identify level of education.

American), and residence (West or Southwest Philadelphia). Eleven of these individuals (3 males and 8 females) participated in one focus group, and the remainder (3 males and 9 females) participated in another group of similar format conducted three months later. The groups were led by two different moderators at a professional focus group facility in Center City, Philadelphia.

Recruitment was conducted in two stages. First, 14 locations (shopping malls and transportation centers) were identified within the targeted urban Southwest Philadelphia area where African American adults, especially seniors, congregate and/or reside. Participants were recruited with flyers and intercepts. Second, presentations were delivered at two senior high rises in the targeted area. Participants were not recruited from doctors' offices, as we were concerned about the bias attributable to a single clinic staff. Nor did we seek persons with a particular type of medical problem or disease. We developed a screening instrument and administered it to persons who displayed an interest. Persons who could not speak English and who did not self-

identify as African American were excluded. Demographic information of participants in both focus groups is presented in Table 1.

Discussion Guide and Questionnaire

We developed a discussion guide and a brief questionnaire that focused on what African Americans viewed as desirable or high-quality health care delivered in a culturally appropriate and competent manner. We thus assumed that competence refers to a performance element of care,¹¹ that is it implies high-quality care in contrast to low-quality care (as defined by the participant), and that attitudes, beliefs, and values (the cultural aspects of our study) related to health and health care are shared among African American adult patients.

In developing the focus group protocol, the authors were guided by attributes of culture in relation to health care in review articles and thematic areas related to those attributes: interpersonal care, individualized treatment, effective communication, technical competence, and language facility.^{15,18–20} Since the intent of the paper was to allow

participants to reveal their perceptions of cultural competence, the focus group protocol did not ask direct questions about these attributes or use checklists of items. Questions included the request for a brief description of the respondent's most recent experience with a healthcare facility or provider followed by a series of items grouped around the following domains:

- Definitions of high-quality health care related to physicians
- Role of culture and ethnicity in the doctor-patient relationship
- Patients' expectations of doctors and patient responsibilities

The moderator structured the discussion as open-ended and conversational. The focus group was approached from a constructivist perspective, based on the idea that people create their own worlds of interpreted meaning, providing (when necessary) rationales for decisions and feelings. To capture what we assumed to be potential essential elements of cultural competence, a 15-item questionnaire consisting of short phrases was distributed to participants near the end of the focus group session. In it, they were asked to rate the importance of various attributes of a healthcare provider (eg, communicates well, understands your role within your family, is of the same ethnic group as you) on a scale of one to five (see Appendix 1).

ANALYSIS

The analysis of the focus group data was categorized in three areas: 1) definitions of high-quality healthcare; 2) role of culture and ethnicity in the doctor-patient relationship; and 3) patients' expectations of doctors and patient responsibilities. Standard techniques of qualitative analysis were employed to tease substantive conclusions from observational and narrative information. These included content

analysis (ie, sorting, comparing, contrasting, aggregating, and synthesizing) and pattern identification (an attempt to determine which patterns are common to several individuals or which are repeated over time). Processing of the data was descriptive. The descriptive process was employed in an effort to isolate the main attitudes, beliefs, and practices of the participants. The responses of participants to the post-session questionnaire on preferred characteristics of physician-patient interaction were analyzed separately by using descriptive statistics.

RESULTS

Definitions of High-Quality Health Care

Defining high-quality health care and specifying how they know when they receive it was something many participants in the first focus group could not do, at least not directly. Some assumed they were getting good care (eg "I presume" or "as far as I know"). Others surmised as much ("Good doctors always have an office full of people"). They were better able to identify instances when they did not get good care:

I had a fall and went to my primary physician, and she gave me medication to use, but the next day my hands started swelling. And after it got so large I had to go back, I was sent to get an X-ray, and deep inside of me I think I should have had an X-ray immediately.

Respondents felt positive about doctors who referred them to specialists:

If you have a problem and they send you to a specialist without a lot of hassle it makes you feel that you're getting the best of care.

Respondents in the second focus group generally defined high-quality health care as proper diagnosis and

treatment followed by a favorable outcome:

If you go with a problem and they get it, fix it, no waiting, and the medicine they prescribe is for you and you have no problem, I would call that high-quality health care.

For several, billing issues were aspects of high-quality care:

I'm often sent to different doctors. Some of them don't seem to even touch you. They come out and do the little things, and before I'm almost home the bill is there, and a high-quality one.

Some said they rely on common sense to tell them whether they are receiving attentive, individually appropriate care instead of just being experimented upon. One recalled a stay in the hospital:

(It looked) like every doctor in (the hospital) got a piece of my body. Every time I'd wake up, new (doctors) would be sitting around my bed, and I didn't feel that was high-quality health care.

Taken together, respondents in both groups wanted to be treated with respect and as individuals. Beyond that, however, they identified the following components of quality health care: availability, accessibility, and concern for their well-being.

Respondents gave their present doctors high marks when asked to rate how comfortable they feel with them. Nonetheless, many reported that a physician-patient relationship had been undermined by insensitivity:

I'm going to this doctor and it was a routine visit and as I was walking out of her office she said, "And by the way, you have diabetes." Just like that. Never any discussion about it or anything.

When respondents were asked if their present healthcare providers were doing enough to keep them healthy,

opinions were divided. Some thought their doctors were doing enough, either because followup was perceived as adequate or because patients were sent to specialists as needed. Other respondents differed for a variety of reasons: one thought she should have been told about classes for diabetics, and others felt that African Americans in general do not receive as effective medications as do other ethnic groups:

Penicillin is a medication that they do not want to give us, and they do give it to other people. I can't get penicillin, and I work for doctors and they have loads of it.

Some felt their doctors do not give them all the information they need to stay healthy. Still, they hesitated to fault the doctors, given the strict time limitations imposed by health maintenance organizations. They nevertheless felt that their potential for efficient and effective communication with their doctor was limited by these time constraints.

Role of Culture and Ethnicity in the Doctor-Patient Relationship

When participants in the first group were asked hypothetically if it would make a difference if their physician were African American, Asian, or Caucasian, they said that race does not matter.

It boils down to your confidence in your doctor. If you have confidence in him, then this is the one for you regardless of who he is.

In fact, three racial categories were represented among the current healthcare providers of the 23 participants in the two groups. Although the providers of most participants were Caucasian, five respondents reported having African American physicians. The groups agreed, however, that the doctor's race made no difference to them:

Color doesn't make a difference as long as they do their job.

When a parallel question was asked in the second focus group ("Would a doctor's ethnic background make a difference in making a decision between two doctors who are equally skilled and equally qualified?"), respondents replied that quality of care was more important than ethnicity.

None felt that their healthcare provider needed to be of the same sex, at least not in the treatment phase. Many female respondents happened to have a female physician (typically because they sought a gynecologist and many gynecologists are female). Participants hesitated when the word culture was first mentioned, but then they proceeded to define it variably. Some equated it with education or appreciation of the arts, whereas others thought it referred to the "ethnic background of a person" or "knowledge, background, the difference in our upbringing." Some identified three disease entities (diabetes, high blood pressure, and lupus) as being common to their ethnic group. Several participants thought that culture had a role in health care because they thought that African Americans were associated with certain foods, such as pork products and fried foods.

Other participants focused on attitudes, particularly denial:

With men, they'll overlook the fact that they have prostate cancer until it's too late. They were in denial or never went to check it out, and based upon the fact that they're macho, macho, that belief factor played a role in their well-being.

Still others spoke of practices such as self-diagnosis and reliance on home remedies:

Good old home remedies could play a role in healthcare because I might use a Southern remedy (instead) of going to the doctor...

Although most respondents viewed the healthcare provider's race as unimportant, several thought the provider should know something about African

American culture. Many respondents felt that patients are best served by doctors who inform themselves fully about both nutrition and ethnicity, but there was this qualifier:

I think if a doctor is going to tell you, you shouldn't eat greens, he should know what he's talking about.

As for the appropriateness of doctors asking patients about cultural issues, respondents thought it depended on how the doctor brought them up and spoke about them. For instance, there was qualified approval of questions focused on a diet of fried chicken and collard greens if they were asked in the context of the patient's health:

I believe in holistic health, and if a doctor is asking about religion, your eating habits, exercise or stress in life, your lifestyle, you have to have a holistic approach towards health in order to get to the root of what's wrong with the person and to heal.

Responses differed greatly when participants were asked how physicians could show that they are knowledgeable and sensitive about African American culture. One said:

He'd have to know something about Black culture, how I live, what caused me to live like I live, why I live like I live. He'd have to know something about the churches, whatever we do as far as a Black race.

One spoke highly of a White doctor who stayed in a predominantly Black neighborhood from the time he was young until he was old, and concluded:

A White American, I would go along with them knowing about Black culture because they've been around us all their lives.

In terms of disease management, one individual reported (approvingly) that a physician had rejected an inappropriate bone-density reading because of different evaluation scales for African Americans and for Caucasians.

Another person claimed (disapprovingly) discrimination between Blacks and Whites in the treatment of high blood pressure, resulting in scant use of stress-management techniques among Black patients. (The latter perception was underscored at another point in the session when respondents were asked if their doctor had ever spoken to them about stress management or how to handle stress; not one responded yes.)

At the other end of the spectrum, few respondents felt that doctors had time for conversations about race and culture.

Patients' Expectations of Doctors and Patient Responsibilities

While cultural concordance, ethnicity, and sex of their physicians were less important to our participants, effective communication was paramount. Respect from their doctor was one component of successful communication. Participants in the second focus group felt that good communication—how patients express themselves to the doctor and how the doctor responds to what they say—is the key to fostering sensitivity to their health beliefs, attitudes, and practices:

If you mention something (you read) to your doctor and he questions you in a positive way. He was like, "I'd like to hear more about that," (as) opposed to saying he's (just a dermatologist) with creams and tests. So I felt that he was interested, and I found the article for him.

Something as mundane and ostensibly amendable to change as the amount of time spent with patients can affect whether or not patients believe that their physician really understands them and is culturally competent. Sadly, participants resigned themselves to the fact that they would have to make the most of their time at doctors' visits. They accepted responsibility for informing themselves on matters of health:

If you're interested in your own health you go out and you seek these things yourself.

Finally, the group was asked about the role the patient should have in determining the type of treatment he or she will receive. Most agreed that the physician's recommendation should be balanced with the patient's decision. Autonomy and the opportunity to take control of their own health management was an integral characteristic of the doctor-patient relationship, as was negotiation.

Although most of the respondents did not believe that the race of their physician affected their doctor-patient relationship or health, it did seem to have an effect on communication within that relationship. Many respondents acknowledged using some form of alternative medicine, from exercise to herbal supplements, both for general health maintenance and to treat specific problems. A few had told their doctors about it, but most felt that doctors were not fully knowledgeable about alternative medicine, although whether or not this ignorance was related to race was unclear. When the moderator inquired if they had ever listed a home remedy they were taking on a doctor's questionnaire form, most said no. When asked if they thought their doctor should ask about their beliefs regarding use of home remedies, most again said no.

Most patients did not seem willing to try to negotiate with their doctors in order to include home remedies in their treatment plan, which suggests that unknown factors prohibit effective communication. They chose either not to inform their doctor of their uses of alternative medicine or to seek advice from another healthcare professional.

Responses to Post-Session Questionnaire

At the conclusion of each focus group session, respondents were asked to complete a brief questionnaire that repeated many of the themes raised in the open-ended discussions. The ques-

tionnaire required rating (on a five-point scale) the level of importance they attached to 15 characteristics of doctor-patient interaction. In response to a single question ("How important is it to you that your healthcare provider _____?"), members of the first focus group indicated unanimously that healthcare providers should communicate well, value the patient's opinion, and be straightforward with information about the patient's health. The second focus group was only unanimous that their doctor should be straightforward with information about the patient's health. Respondents in the first focus group were nearly as emphatic that the healthcare provider should speak the same language as the patient and be pleasant (although one person was neutral on the latter point). The second group was almost as insistent that their doctor be an effective communicator. Most participants in both focus groups thought their healthcare provider's race/ethnicity did not have to be concordant with their own.

CONCLUSIONS

We conducted a qualitative study with two focus groups followed by responses to a questionnaire to determine how African Americans perceive culturally competent care. Despite individual differences in ease of articulating definitions of high-quality health care, participants focused on professional demeanor, appropriate diagnosis (by specialists if need be), effective treatment, effective communication, and respect as critical aspects of care. Those who could not be more specific relied on a "feeling" that the physician either was or was not responding to their problems. The length of the interaction also influenced patients' ratings of their doctor's competence, although patients recognize that this element is sometimes beyond the control of the physician. Most participants thought that physi-

cians should know something about African American culture (preferably after long-term contact with African American patients), but they emphasized that references or questions about their culture are appropriate only in the context of healthcare issues. Respondents varied greatly in their knowledge of and receptivity to alternative medicine, but those who believed in the effectiveness of alternative remedies did not view their healthcare providers as credible discussants in that area, particularly with regard to herbal medicine. Therefore, they did not want their doctors to raise issues of alternative medicine with them. We noted minimal concern about concordant race and sex of the physician. Thus, to these individuals, a culturally competent doctor will help them overcome their health problem while showing respect and using effective communication methods.

Effective communication was central to the comments of many patients in evaluating the knowledge and/or competence of the physician as well as his/her sensitivity to the patient's particular health beliefs, attitudes, and practices. Those qualities considered very important included valuing the patient's opinion, speaking the same language, and providing the patient with straightforward information regarding her/his health. The significance of communica-

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tion to patient satisfaction and health care is well documented.^{12,21} Others have found that minorities are attentive to and perceive poorer communication from their physicians. In a recent study from the Commonwealth Fund, "33 percent of Hispanics, 27 percent of Asian Americans, 23 percent of African Americans, and 16 percent of Whites reported one or more of the following problems: their doctor did not listen to everything they said, they did not fully understand their doctor, or they had questions during the visit but did not ask them."²²

Perceived respect by physicians was a crucial aspect of the doctor-patient relationship. One element of respect was the need to feel as though the relationship was a partnership in which the doctor genuinely wanted to know how patients defined their illness and that the treatment would be jointly devised. Evidence of patients' desire for respect is found in other studies. In a national survey, 16% of African Americans felt as if they had been treated disrespectfully during a visit to their doctor's office.²² Saha et al compared Black patients with racially concordant physicians to those without and inferred that communication and respect were improved in the former relationship.¹⁴ Black patients with Black physicians reported that their doctor provided them with excellent health care, treated them with respect, explained their medical problems, listened to their concerns, and were readily accessible. Among the physician behaviors indicative of the quality of the patient-physician interaction, treating patients with respect was the strongest predictor of overall satisfaction with care among Blacks who have racially concordant physicians.¹⁴

Our finding that physician racial concordance was of little or no concern to our subjects is consistent with findings in recent cultural competence literature.²³ The significance of racial concordance in the doctor-patient relationship is incompletely understood,

partly because patients have seldom been queried about their preferences and the underlying reasons for those preferences. While Black physicians make up 4% of the physician workforce, 25% of Black patients receive care from Black physicians. In a national survey, 23% of the Black patients who had Black doctors used race or ethnicity as a criterion for physician selection, whereas 10% of the Black patients who chose non-Black physicians used race or ethnicity as a criterion for selection.²⁴ Additionally, Black patients with Black physicians are more likely than those without Black physicians to indicate that they seek preventive care as well as needed medical care.¹⁴

In most studies, African Americans as well as other minority subjects ranked their physicians low on a participatory decision-making score compared to the rankings given to physicians by White subjects. But for both African Americans and Whites, subjects whose physicians were the same race ranked their physicians higher on the participatory decision-making continuum than those whose physicians were not.¹³ Another study used audiotaped visits and found that race-concordant visits were 2.2 minutes longer, characterized by communication with slower speech speed and more positive patient affect.²¹ However, these findings were not explained by objective measures of key elements of communication. On the contrary, Kaplan et al found that minority patients experienced more participatory interaction in race-discordant relationships.¹² This statistical finding was not significant for non-minority patients. As a whole, these findings point out that minority patients are more likely to perceive that they are getting better health care when they see a minority physician. Thus, for many patients, racial concordance is important, but objective measures of communication style have not uncovered what element of concordance is explanatory. Since a positive interaction

between physician and patient is essential to healthcare delivery and to health outcomes, additional research should be directed to understanding cross-cultural aspects of the doctor-patient relationship.

Because older adults are less likely than children and young adults to have adopted the attributes of the mainstream culture, the finding that the influence of culture on healthcare interactions is important in this age group is unsurprising.²⁰ Medical professionals have begun to develop extensive ethnogeriatrics curricula, such as the Stanford ethnogeriatrics module, which contains components on culturally appropriate care and assessment,²⁵ and reviews on cultural aspects of caring for older adults in primary care texts.²⁰ Drawing on this literature and others, Kobylarz created a mnemonic framework of questions in seven categories, the ETHNICS (Explain, Treatment, Healers, Negotiate, Intervention, Collaborate, Spirituality) tool, which practitioners can use in providing culturally appropriate geriatrics care.²⁶ This mnemonic and others have high face validity, but none are derived from research that elicit the perceptions of patients. All of these tools provide guidance in areas such as communication, but they often do not specify the meaning of terminology. For example showing respect is increasingly shown as critical to some persons, but one would not know to focus on this aspect of communication just from following the checklists or guidelines that directs one to open communication.

The study contains some notable limitations. The limited size and design of the study prohibit generalizability, and the lack of homogeneity across ages and sexes also restricts inferences about these attributes. Expectations of the doctor-patient interaction may vary depending on the nature of the health problem, but this study did not control for the nature of the health experience (chronic versus acute, preventive or

curative, and stage or severity). In addition, we do not know how much interaction the participants have with doctors. However, as with all focus group studies, our goal was to elucidate perceptions and meaning rather than to establish generalizability. The focus group discussion guide may have been too restrictive or too broad. However, our intent was to frame the questions in the context of the doctor-patient relationship without using a predetermined bias about the specific elements or dimensions of culture, competence, or cultural competence.

Other limitations are generic to focus group methods.²⁷ Focus group methods do not offer as much breadth as quantitative methods, nor are they intended to arrive at solutions comparable to other qualitative approaches such as nominal group or Delphi processes. Just as the measures in quantitative methods must be valid, the focus group discussion guide must be relevant to the intent of the focus groups, and the interviewer must be skillful enough to ask directed, but open-ended, questions. We used trained focus group interviewers to lead the groups. Quantitative methods have more breadth but lack the depth of the qualitative method.

This study can be a foundation for others that explore the meaning of cultural competence. Similar to other studies, the African Americans in this study were concerned about generic interpersonal aspects such as professional demeanor and effective communication but were also concerned with respect, a more culture-specific interpersonal attribute. However, unlike other studies of cultural competence, our results emphasize the importance of biomedical performance outcomes to African Americans. Most of these 23 individuals wanted health care that is equal in regard to technical performance to that received by others. Therefore, we recommend that physicians be attentive to patient expectations of the technical

aspects of care, as well as their expectations of effective communication and respectful treatment. Whether technical performance is more or equally important to the interpersonal aspects of care is unknown. One might speculate that the emphasis on performance (getting better) of these African American seniors resulted from documented feelings of neglect by the healthcare system and the subsequent desire to demand services in order to receive one's due. Future research on the significance of cultural competence in the doctor-patient relationship should elicit the full range of competence—technical performance, process of care, and cultural beliefs and preferences.

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Design concept of study: Johnson, Slusar, Johnsen
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Data analysis interpretation: Johnson, Slusar, Chaatre, Johnsen
Manuscript draft: Johnson, Slusar, Johnsen
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APPENDIX 1 CULTURALLY COMPETENT MEDICAL CARE Post Focus Group Questionnaire

Please read the following statements and rate how important they are to you.
(1=low, not important; 5=high, very important; NR=no rating)

How important is it to you that your healthcare provider:

	1	2	3	4	5	
	low				high	NR
Communicates well						
Speaks the same language as you						
Understands what you think, as well as what is wrong with you						
Is objective						
Is located near you						
Values your opinion						
Is pleasant						
Is non-judgmental						
Understands your family's role in your health care						
Is straightforward with information about your health						
Understands your role within your family						
Is close to your age						
Practices the same religion as you						
Is the same sex as you						
Is the same ethnic group as you						