PROVIDER FACTORS AFFECTING ADHERENCE: CULTURAL COMPETENCY AND SENSITIVITY

Debra J. Barksdale, PhD, FNP

In this article, lessons learned from the Chronic Care Model are discussed by addressing provider factors that may affect the delivery of care and patient adherence. Specifically, issues related to the provision of culturally competent and sensitive care are discussed in terms of race-concordant and discordant patient-provider relationships. Strategies for beginning and continuing the process of becoming culturally competent are presented, such as the ASKED framework for determining one's level of cultural competency and the LEARN framework for enhancing the patient-provider relationships. Lastly, tips are presented to assist providers in knowing their patients better which will ultimately enhance cultural competency and patient adherence to treatment regimes. (*Ethn Dis*. 2009;19[Suppl 5]:S5-3–S5-7)

Key Words: Providers, Cultural Competency, Sensitivity, Adherence, Concordance, Discordance, ASKED, LEARN

From The University of North Carolina at Chapel Hill, School of Nursing, Chapel Hill.

Address correspondence and reprint requests to Debra J. Barksdale, PhD, FNP; The University of North Carolina at Chapel Hill; School of Nursing; Carrington CB 7460; Chapel Hill, NC 27599-7460; 919-843-2479; 919-843-9969 (fax); djbarksdale @unc.edu

Article presented in part at the 24th Annual International Interdisciplinary Conference on Hypertension and Related Cardiovascular Risk Factors in Ethnic Populations - International Society on Hypertension in Blacks, July 10–12, 2009, Chicago, Illinois.

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This article addresses strategies for improving patient adherence based on lessons learned from the Chronic Care Model. The focus is on provider factors affecting the delivery of care and patient adherence, with special emphasis on issues related to cultural competency and sensitivity. Based on the Chronic Care Model, the goal of providers should be to provide care that patients understand and that fits with their cultural background.

THE CLICHÉ OF CULTURE

We are often confronted with the many terms used to describe culture. These include cultural competency, cultural sensitivity, cultural awareness, cultural knowledge, cultural skill, cultural encounters, cultural desire, cultural barriers, and cultural context among others.[1] We hear the word culture so often that it's true meaning becomes lost and so the word loses its power and becomes a cliché. So what is culture? There are several meanings for culture. For example, it can mean a group of people who share beliefs, values, customs, practices or behavior. It also means being refined and having knowledge and sophistication. Still, it can mean to till as in to cultivate in preparation for growth or to develop or refine a skill through practice, preparation and training. Instead of seeing culture as something that minority and ethnic groups have or something that people from other countries have, what if culture was viewed from a perspective that respected the refinement and knowledge that patients bring? What if health care was seen as cultivating growth in groups and helping them to develop or refine the skills that they need to be partners in their own health self-management? We might then value cultural differences and the uniqueness that it brings rather than seeing culture as a nuisance to our evidenced-based treatment guidelines and protocols.

So, what is culture? My colleague, Dr. Rumay Alexander wrote, ''Culture, like genetics, not only has a group definition, but also an individual expression.''[2] As an example, in a course on racial and cultural issues in health care, a discussion was held on ''colored peoples' time'' (CPT) and ''Indian time.'' These phrases are based on stereotypes that African Americans and Native Americans will always be late. One White student asked, ''So if I have an appointment with an African American or Native American should I just always expect that they will be late?'' Certainly not! Some might be late, just like some Whites might be late but this group stereotype cannot be applied to every individual in the group.

CULTURAL COMPETENCY AND CULTURAL SENSITIVITY

Cultural competency is a process of delivering health care within the context of a patient's beliefs, values, and customs. Often in the United States, we tend to use the terms race, ethnicity, and culture interchangeably although they are not the same. An excellent and broad definition of cultural competency is found on the website of the Oregon Department of Human Services. This definition includes many of the ways in which groups of people might differ. It states, ''Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diver-

sity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes."[3]

Culturally competent healthcare providers must first believe that diversity is important (cultural desire). Culturally competent providers should conduct a self assessment to determine their own biases toward other groups and learn to manage their thoughts about differences (cultural awareness). These providers should also try to acquire the necessary cultural knowledge and skills to be able to interact respectfully and competently with patients from different cultures (cultural encounters). The culturally competent healthcare provider learns to adapt their care in a manner that reflects understanding of and value for diversity. These providers must be aware of biases and stereotypes that prevent them from interacting optimally with their patients from different backgrounds and cultures (cultural barriers). They must also be aware that there might be barriers that are put up by various cultures to keep others out. For example, some African Americans are taught that you never let White people know your home business or that you never let them see you sweat.

An example of caring for a patient in a manner that reflects understanding and value for diversity is one used in a course for nurse practitioners. The nursing students are asked to respond to a scenario in which a 55-year-old grandmother who is the CEO of a corporation has recently acquired custody of her school-aged grandchildren. She tells the provider how difficult this is because she is always tired and is having trouble coping. The provider gives her information on a group called *Grandparents Parenting Again* and then tells her that God would not put more on her than she can bear. Students are asked if the response was appropriate. Most students say no emphatically but one student very eloquently made a case that it might be appropriate depending on the relationship between the patient and the provider and the religious beliefs that the patient has. In other words, this might be exactly what the patient needs to hear. Cultural competency is about knowing, valuing, respecting, and accepting the patient's beliefs and it is developed over a period of time.

Cultural sensitivity implies that one is receptive to differences between and among cultural groups. However, simply being aware of differences does not mean that the providers will skillfully interact with people from cultures different from their own. Foronda describes cultural sensitivity as having the following attributes: knowledge of, or information about, cultural differences; consideration of, or concern, for others; understanding, perception, and comprehension of the values of others; respect, appreciation, or regard for other cultures; and finally tailoring or the ability to adapt interventions to meet the needs of patients from varying cultures.[4]

It is very important that healthcare providers realize that neither culture competency nor cultural sensitivity assumes that the provider should possess full knowledge of the practices, beliefs, values or customs of every culture or individual. Most people will share their beliefs if providers are willing to, and have the time to listen.

CULTURAL COMPETENCY IN RACE-CONCORDANT AND RACE-DISCORDANT PATIENT-PROVIDER RELATIONSHIPS

In 2004, at a conference on workforce diversity in Rochester, New York, Dr. David Satcher, the 16th Surgeon General of the United States delivered the keynote address entitled, *Eliminating Health Outcome Disparities: If You Want High Quality Health Care, It's Good to Speak English, Be White, and Rich*. The literature and health statistics describe what happens when patients do not fit these criteria. For example, Schnittker and Lang write that Blacks are less likely to have cardiac catherization, to receive diagnostic procedure for cancer, to receive analgesia for fractures or to be active on kidney transplant list.[5] They are also less likely to report that they were allowed to participate in the visits with physicians and more likely to report that they receive less respect from physicians.[5] These types of examples are not new but they do highlight some of the problems with health care and patient-provider relationships in the United States.

The Institute of Medicine (IOM) compiled evidence in their report, *In the Nation's Compelling Interest Ensuring Diversity in the Health-Care Workforce*, to support that when given a choice, racial and ethnic minorities tend to choose healthcare providers from similar racial and ethnic backgrounds and are more satisfied with their care overall.[6] Another IOM report, *Unequal Treatment*, recommends that the proportion of minority healthcare providers be increased.[7] Both reports suggest that race-concordance (patient and provider are of same racial and/or ethnic group) is important in patient-provider relationships. The assumption is that these types of relationships foster better health outcomes for the patient. The major problem is that there are not enough providers from racial and ethnic minority groups to meet the healthcare needs of the minority populations, therefore, all healthcare providers should develop the skills to provide high quality care to various racial, ethnic, and cultural groups.

DOES RACE-CONCORDANCE REALLY MATTER?

The literature is mixed on whether or not racial concordance between the

patient and provider is important. Still, the prevailing notion is that patient satisfaction and healthcare outcomes are improved when the patient and the provider are of the same racial or ethnic group. Using data from *The Kaiser Family Foundation Survey of Race, Ethnicity and Medical Care: Perceptions and Experiences*, Schnittker and Liang sought to explore beliefs about the effects of concordance and patient-provider interactions.[5] The sample of 3,884 people included 1,189 Blacks and 983 Latinos. In this study, 64% of the sample reported that race of the physician or nurse did not matter to them. However, Blacks and Latinos were more likely to report a belief that racisms occurs more often in discordant interactions. Interestingly, Black and Latinos also seemed to believe that racism occurs, although less frequently, in concordant interactions. They believed that an important source of unfair treatment was related to their type of insurance or inability to pay.

An important lesson from this study is that race-concordance alone does not assure that providers will demonstrate cultural competence. In fact, differences in socioeconomic status as well as internalized racism may also hinder communication in racially concordant interactions.[8]

In a study focusing on relationships between dentists and African American patients, Williams and colleagues found that the 292 Black patients receive similar care as White patients when the dentists were White.[9] Overall patient satisfaction was high but Black patients reported significantly lower rating for how well the provider knew them than White patients did. Further, there was significantly less chatting between Black patients and White dentists.

In another study, Gordon et al explored whether physician-patient communication was affected by race in patients with lung cancer or pulmonary nodules.[10] From audiotaped interactions between 137 patients and their physicians, these researchers found that Black patients and their families received much less information than White patients. Further, Black patients received significantly fewer active participation utterances from their White physicians than White patients did. Communication in discordant relationships resulted in less information being given to the patients and less patient participation in the encounter.

Whether real or perceived, discrimination in healthcare does affect patients' health behaviors and outcomes. Facione and Facione found that among 817 women, perceived prejudice in health care was associated with decreased adherence to cancer detection behaviors.[11] Sohler et al found that patients with HIV in race-concordant patient-provider relationships had less mistrust of the healthcare systems than those in discordant relationships.[12] An interesting finding of this study was that Black patient with Hispanic provider relationships and Hispanic patient with Black provider relationships resulted in greater mistrust of the healthcare system than in relationships where the provider was White. Perhaps some minority patients prefer concordant relationships but, when concordant relationships are not possible, prefer White providers over those from a different racial or ethnic minority group. In exploring perceived medical errors and racial concordant relationships, Stepanikova found that White patients are less likely to report medical errors if their treating physicians are White.[13] For non-White patients, race concordance did not affect perceived medical errors. Stepanikova speculated that White patients might perceive their non-White physicians as less competent while minority patients are less likely to question or doubt their physician.[13]

The question remains, does race-concordance matter? This depends to a large extent on patients' expectations, experiences, and personal choices.[5] Our role as providers is to maintain a patient-centered approach and continue the process of becoming culturally competent and delivering individualized and sensitive care.

PROVIDER CHARACTERISTICS AFFECTING PATENT CARE AND ADHERENCE

There is much in the literature about health disparities and how provider characteristics might contribute to those disparities. Some provider factors affect whether or not patients will adhere to prescribed regimes.[14] Providers might lack knowledge about a specific cultural group or practice. When unaware providers do not seek input from their patients, the chances that patients can and will follow the prescribed management plans may be reduced.[14] Other provider factors that affect patient adherence include:

- Self-protection or denial that there are cultural differences that matter. [14]
- Fear or unwillingness to learn something new or to try a new approach.[14]
- The reality of time constraints which limit providers in getting to know their patients.[14]
- Miscommunication leading to less than optimal care.[5]
- Difficulty when the patient complaints do not fit the diagnostic paradigm or guidelines that they are accustomed to.[5]
- Provider holds biases and stereotypes such as Blacks are lazy, unmotivated, or not compliant.[5]

Further, Berger summarized literature highlighting demographic characteristics of physicians that affect concordant and discordant patient-provider interactions.[15] The physician's sex, ethnicity, religion, and culture can all present barriers to effective patient care, for example: medications are often

under-prescribed to minority patients; patient's ethnicity and sex influences whether or not they will receive certain cardiac procedures; physicians are less likely to recommend weight loss to men compared to women; and Black women receive fewer referrals for mammograms and screening for osteoporosis.

ASKED YOURSELF: EVALUATING CULTURAL COMPETENCY

In the process of becoming culturally competent, providers should assess their level of comfort and desire for building proficiency in this area. The ASKED model, developed by Campinha-Bacote,[16] is a simple framework for evaluating one's own cultural competency. This model consists of questions that providers should ask themselves to assess their individual cultural competence in the following areas:

A-Awareness: Assessment of one's own biases and prejudices
S-Skill: Evaluation of one's level of skill in evaluating other cultures
K-Knowledge: Determination of the information or data that one has on racial, ethnic, and cultural groups
E-Encounters: Extent to which the provider has interactions with other groups
D-Desire: Motivation and willingness to become culturally competent

THE LEARN FRAMEWORK

There are several frameworks to guide the provider's journey in becoming a culturally competent practitioner. One such model is LEARN developed by Berlin and Fowkes.[17] The LEARN framework serves as an adjunct to the usual health interview and assists healthcare providers in optimizing their patient encounters and patient adherence. The pneumonic has five components:

L-Listen. Providers should practice listening that allows the patient to share their perspective on the problem. "Listen with sympathy and understanding…"[17] which includes allowing the patient to share their perceptions of the causes, trajectory, treatments, resources and eventual health outcomes related to their condition. Berlin and Fowkes provide examples of the types of question that one might use to encourage patients to talk.[17]

E-Explain. As healthcare experts, it is very easy to get into the habit of telling patients what the provider thinks they should know. All too often, providers use medical jargon that the patient cannot easily understand. Explaining represents the provider's efforts to communicate their impressions, or perceptions of the problem with the patient.

A-Acknowledge. Acknowledging the differences between the patient's and the provider's own perceptions of the problem is perhaps one of the most difficult areas for healthcare providers. The provider is trained in matters of health but patients might have legitimate reasons for beliefs or courses of action related to the health condition or situation. Providers should avoid making patients feel ignorant or stupid. By acknowledging differences, the provider can then discuss and clarify these differences.

R-Recommend Treatment. Recommending treatment implies that the patient has a say in whether or not to accept a specified course of therapeutic actions. The recommended treatment should take into consideration the patient's values, beliefs, and cultural practices to increase the chances that they will accept the recommended course of treatment.

N-Negotiate Agreement. The final step is to negotiate agreement. Berlin and Fowkes suggest that this is the key step in the whole process.[17] If a patient cannot or will not adhere to a recommended course of treatment (because they did not agree to it in the first place) then the therapeutic value of that treatment is diminished. The patient and provider must work together to develop a mutually satisfactory plan of care.

THE ETHNIC FRAMEWORK

ETHNIC is another framework for providing culturally competent care.[18] The components of this pneumonic include determining how patients *explain* their illness, what *treatments* they have already tried, and if they have obtained services from folk *healers*. Additionally, as with LEARN, providers should *negotiate* treatment options and agree on the *interventions* using a *collaborative* process with the patient, the family, and others who might be directly involved in the care.

OTHER STRATEGIES

Other strategies that might be useful in the provision of culturally competent care include: integrating cultural competency into curricula for healthcare professionals;[19] using trained interpreters to enhance communication when needed; employing individuals in your practices that reflect the diversity of your patient population; seeking development and training related to cultural diversity; and accepting or at least considering alternative forms of healing and therapies.

CONCLUSION

Sir William Osler, who was once considered the most influential physician in history, was quoted as saying, "It is much more important to know what sort of person has a disease, than what sort of disease a person has." In conclusion, the following suggestions, adapted from *10 Tips for Delivering Culturally Competent Care*[20] will assist providers in knowing their patients and providing culturally competent care. For each patient, the provider should determine:

1. Where the patient was born and what this might mean for their health.
2. What the patient's primary language is? Do they speak a different language at home?
3. Cultural dietary patterns.
4. Religious beliefs and if any treatments are prohibited based on their beliefs.
5. How the patient describes or explains the illness.
6. Level of function, independence, and quality of life before the patient-provider encounter.
7. Usual manner for dealing with illness.
8. Emotional and mental health of the patient.
9. Support systems.
10. How to tailor treatment for the individual patient sitting in front of you.

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