COURSE #97431— 2 CONTACT HOURS/CREDITS Release: 03/01/25 Expiration: 02/29/28

Cultural Competence: An Overview

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners

John M. Leonard, MD
Mary Franks, MSN, APRN, FNP-C
Randall L. Allen, PharmD

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all members of the interprofessional healthcare team.

Accreditations & Approvals

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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This activity has been designated for 2 Lifelong Learning (Part II) credits for the American Board of Pathology Continuing Certification Program.

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This activity was planned by and for the healthcare team, and learners will receive 2 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 2.4 hours for Alabama nurses.

AACN Synergy CERP Category B.

NetCE designates this activity for 2 hours ACPE credit(s). ACPE Universal Activity Numbers: JA4008164-0000-25-019-H04-P and JA4008164-0000-25-019-H04-T.

Individual State Nursing Approvals

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Special Approvals

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency, and California Assembly Bill 241, Implicit Bias.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to provide members of the interprofessional healthcare team with the knowledge, skills, and strategies necessary to provide culturally competent and responsive care to all patients.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define cultural competence, implicit bias, and related terminology.
2. Outline social determinants of health and barriers to providing care.
3. Discuss best practices for providing culturally competent care to various patient populations.
4. Discuss key aspects of creating a welcoming and safe environment, including avoidance of discriminatory language and behaviors.

Pharmacy Technician Learning Objectives

Upon completion of this course, you should be able to:

1. Define and identify terms related to cultural competence and its impact on health care.
2. Describe how a practice can be enhanced to be culturally sensitive and safe for all patients.

INTRODUCTION

Culturally competent care has been defined as "care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender, and sexual orientation" [1]. A culturally competent person is someone who is aware of how being different from the norm can be marginalizing and how this marginalization may affect seeking or receiving health care [1]. To be effective cross-culturally with any diverse group, healthcare professionals must have awareness, sensitivity, and knowledge about the culture involved, enhanced by the use of cross-cultural communication skills [2].

Healthcare professionals are accustomed to working to promote the healthy physical and psychosocial development and well-being of individuals within the context of the greater community. For years, these same professionals have been identifying at-risk populations and developing programs or making referrals to resources to promote the health and safety of at-risk groups. But, because of general assumptions, persistent stereotypes, and implicit and explicit biases, culture-related healthcare disparities persist [2]. In the increasingly diverse landscape of the United States, assessing and addressing culture-related barriers to care are a necessary part of health care. This includes seeking to improve one's cultural competence and identifying blind spots and biases.

DEFINITIONS

CULTURAL COMPETENCE

In healthcare, cultural competence is broadly defined as practitioners' knowledge of and ability to apply cultural information and appreciation of a different group's cultural and belief systems to their work [4]. It is a dynamic process, meaning that there is no endpoint to the journey to becoming culturally aware, sensitive, and competent. Some have argued that cultural curiosity is a vital aspect of this approach.

CULTURAL HUMILITY

Cultural humility refers to an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups. Practitioners who apply cultural humility readily concede that they are not experts in others' cultures and that there are aspects of culture and social experiences that they do not know. From this perspective, patients are considered teachers of the cultural norms, beliefs, and value systems of their group, while practitioners are the learners [5]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [6].

DISCRIMINATION

Discrimination has traditionally been viewed as the outcome of prejudice [7]. It encompasses overt or hidden actions, behaviors, or practices of members in a dominant group against members of a subordinate group [8]. Discrimination has also been further categorized as lifetime, which consists of major discreet discriminatory events, or everyday, which is subtle, continual, and part of day-to-day life and can have a cumulate effect on individuals [9].

DIVERSITY

Diversity "encompasses differences in and among societal groups based on race, ethnicity, gender, age, physical/mental abilities, religion, sexual orientation, and other distinguishing characteristics" [10]. Diversity is often incorrectly conceptualized into singular dimensions as opposed to multiple and intersecting diversity factors [11].

INTERSECTIONALITY

Intersectionality is a term to describe the multiple facets of identity, including race, gender, sexual orientation, religion, sex, and age. These facets are not mutually exclusive, and the meanings that are ascribed to these identities are inter-related and interact to create a whole [12]. This term also encompasses the ways that different types and systems of oppression intersect and affect individuals.

PREJUDICE

Prejudice is a generally negative feeling, attitude, or stereotype against members of a group [13]. It is important not to equate prejudice and racism, although the two concepts are related. All humans have prejudices, but not all individuals are racist. The popular definition is that "prejudice plus power equals racism" [13]. Prejudice stems from the process of ascribing every member of a group with the same attributes [14].

RACISM

Racism is the "systematic subordination of members of targeted racial groups who have relatively little social power…by members of the agent racial group who have relatively more social power" [15]. Racism is perpetuated and reinforced by social values, norms, and institutions.

There is some controversy regarding whether unconscious (implicit) racism exists. Experts assert that images embedded in our unconscious are the result of socialization and personal observations, and negative attributes may be unconsciously applied to racial minority groups [16]. These implicit attributes affect individuals' thoughts and behaviors without a conscious awareness.

Structural racism refers to the laws, policies, and institutional norms and ideologies that systematically reinforce inequities, resulting in differential access to services such as health care, education, employment, and housing for racial and ethnic minorities [17; 18].

BIAS: IMPLICIT AND EXPLICIT

In a sociocultural context, biases are generally defined as negative evaluations of a particular social group relative to another group. Explicit biases are conscious, whereby an individual is fully aware of his/her attitudes and there may be intentional behaviors related to these attitudes [19]. For example, an individual may openly endorse a belief that women are weak and men are strong. This bias is fully conscious and is made explicitly known. The individual's ideas may then be reflected in his/her work as a manager.

FitzGerald and Hurst assert that there are cases in which implicit cognitive processes are involved in biases and conscious availability, controllability, and mental resources are not [20]. The term "implicit bias" refers to the unconscious attitudes and evaluations held by individuals. These individuals do not necessarily endorse the bias, but the embedded beliefs/attitudes can negatively affect their behaviors [21; 22; 23; 24]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [24].

Implicit biases can start as early as 3 years of age. As children age, they may begin to become more egalitarian in what they explicitly endorse, but their implicit biases may not necessarily change in accordance to these outward expressions [25]. Because implicit biases occur on the subconscious or unconscious level, particular social attributes (e.g., skin color) can quietly and insidiously affect perceptions and behaviors [26]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [27]:

- Age
- Disability
- Education
- English language proficiency and fluency
- Ethnicity
- Health status

- Disease/diagnosis (e.g., human immunodeficiency virus [HIV])
- Insurance
- Obesity
- Race
- Socioeconomic status
- Sexual orientation, gender identity, or gender expression
- Skin tone
- Substance use

An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities [20; 28]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages [28].

When the concept of implicit bias was introduced in the 1990s, it was thought that implicit biases could be directly linked to behavior. Despite the decades of empirical research, many questions, controversies, and debates remain about the dynamics and pathways of implicit biases [21].

Specific conditions or environmental risk factors have been associated with an increased risk for certain implicit biases, including [104; 105]:

- Stressful emotional states (e.g., anger, frustration)
- Uncertainty
- Low-effort cognitive processing
- Time pressure
- Lack of feedback
- Feeling behind with work
- Lack of guidance
- Long hours
- Overcrowding
- High-crises environments
- Mentally taxing tasks
- Juggling competing tasks

ROLE OF INTERPROFESSIONAL COLLABORATION AND PRACTICE

The study of implicit bias is appropriately interdisciplinary, representing social psychology, medicine, health psychology, neuroscience, counseling, mental health, gerontology, gender/sexuality studies, religious studies, and disability studies [28]. Therefore, implicit bias empirical research and curricula training development lends itself well to interprofessional collaboration and practice (ICP).

The main characteristics of IPC allow for implicit and explicit biases to be addressed by the interprofessional team. One of the core features of IPC is sharing—professionals from different disciplines share their philosophies, values, perspectives, data, and strategies for planning of interventions [29]. IPC also involves the sharing of roles, responsibilities, decision making, and power [30]. Everyone on the team employs their expertise, knowledge, and skills, working collectively on a shared, patient-centered goal or outcome [30; 31].

Another feature of IPC is interdependency. Instead of working in an autonomous manner, each team member's contributions are valued and maximized, which ultimately leads to synergy [29]. At the heart of this are two other key features: mutual trust/respect and communication [31]. In order to share responsibilities, the differing roles and expertise are respected.

Experts have recommended that a structural or critical theoretical perspective be integrated into core competencies in healthcare education to teach students about implicit bias, racism, and health disparities. This includes [32]:

- Values/ethics: The ethical duty for health professionals to partner and collaborate to advocate for the elimination of policies that promote the perpetuation of implicit bias, racism, and health disparities among marginalized populations.

- Roles/responsibilities: One of the primary roles and responsibilities of health professionals is to analyze how institutional and organizational factors promote racism and implicit bias and how these factors contribute to health disparities. This analysis should extend to include one's own position in this structure.
- Interprofessional communication: Ongoing discussions of implicit bias, perspective taking, and counter-stereotypical dialogues should be woven into day-to-day practice with colleagues from diverse disciplines.
- Teams/teamwork: Health professionals should develop meaningful contacts with marginalized communities in order to better understand whom they are serving.

Adopting approaches from the fields of education, gender studies, sociology, psychology, and race/ethnic studies can help build curricula that represent a variety of disciplines [33]. Students can learn about and discuss implicit bias and its impact, not simply from a health outcomes perspective but holistically. Skills in problem-solving, communication, leadership, and teamwork should be included [33].

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Healthy People 2030 groups social determinants of health into five categories [34]:

- Economic stability
- Education access and quality
- Health care access and quality
- Social and community context
- Neighborhood and built environment

These factors have a major impact on people's health, well-being, and quality of life. Examples of social determinants of health include [34]:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Social determinants of health also contribute to wide health disparities and inequities. For example, people who lack access to grocery stores with healthy foods are less likely to have good nutrition, which raises the risk of heart disease, diabetes, and obesity and lowers life expectancy compared with those who have easier access to healthy foods [34].

Promoting healthy choices will not eliminate these and other health disparities. Instead, public health organizations and their partners must take action to improve the conditions in people's environments. Healthcare providers play a role by identifying factors affecting the health of their patients, providing resources (when appropriate), and advocating for healthy environments.

BARRIERS TO PROVIDING CARE

Culturally diverse patients experience a variety of barriers when seeking health and mental health care, including:

- Immigration status
- Lower socioeconomic status
- Language barriers
- Cultural differences
- Lack of or poor health insurance coverage
- Fear of or experiences with provider discrimination
- Mistrust of healthcare systems

Such obstacles can interfere with or prevent access to treatment and services, compromise appropriate referrals, affect compliance with recommendations, and result in poor outcomes. Culturally competent providers build and maintain rich referral resources to meet patients' diverse needs.

Encountering discrimination when seeking health or mental health services is a barrier to optimal care and contributor to poorer outcomes in under-represented groups. Some providers will not treat patients because of moral objections, which can affect all groups, but particularly those who are gender and/or sexual minorities, religious minorities, and/or immigrants. Since the mid-2010s, several states have passed laws allowing individual health providers to refuse to provide services if doing so would violate their morals or religious beliefs [35]. However, it is important to remember that providers are obligated to act within their profession's code of ethics and to ensure patients receive the best possible care.

BEST PRACTICES FOR CULTURALLY RESPONSIVE CARE

The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [36].

The first step is to engage patients. In nonemergent situations, it is important to establish rapport before asking a series of assessment questions or delving deeply into history taking. Providers should use simple gestures as culturally appropriate (e.g., handshakes, facial expressions, greetings) to help establish a first impression. The intent is that all patients feel understood and seen following each interaction. Culturally responsive interview behaviors and paperwork should be used at all times [36].

When engaging in any patient teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Patients should be encouraged to collaborate in every step of their care. This consists of seeking the patient's input and interpretation and establishing ways they can seek clarification. Patient feedback can then be used to help identify cultural issues and specific needs. If appropriate, collaboration should extend to include family and community members.

Assessment should incorporate culturally relevant themes to gain a better understanding of patients and identify their cultural strengths and challenges. Themes include [36]:

- Immigration history
- Cultural identity and acculturation
- Membership in a subculture
- Beliefs about health, healing, and help-seeking
- Trauma and loss

In some cases, it may be appropriate and beneficial to obtain culturally relevant collateral information, with the patient's permission, from sources other than the patient (e.g., family or community members) to better understand beliefs and practices that shape the patient's cultural identity and understanding of the world.

Practitioners should work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group(s). An instrument's cultural applicability to the population being served should be assessed, keeping in mind that research is limited on the cross-cultural applicability of specific test items or questions, diagnostic criteria, and concepts in evaluative and diagnostic processes [36].

Typically, culturally responsive care includes holistic treatment goals that aim to improve physical health and spiritual strength; utilize strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognize that treatment planning is a dynamic process that evolves along with an understanding of patient history and treatment needs.

In addition to these general approaches, specific considerations may be appropriate for specific populations. While discussion of every possible patient subgroup is outside of the scope of this course, an overview of some of the most commonly marginalized populations are outlined in the following sections [36].

RACIAL BACKGROUNDS

Race and color impact the ways in which individuals interact with their environments and are perceived and treated by others. Race is defined as groups of humans divided on the basis of inherited physical and behavioral differences. As part of the cultural competence process and as a reflection of cultural humility, practitioners should strive to learn as much as possible about the specific racial/ethnic populations they serve [37]. However, considerable diversity exists within any specific culture, race, or ethnicity [37]. Cultural beliefs, traditions, and practices change over time, both through generations and within an individual's lifetime. It is also possible for the differences between two members of the same racial/ethnic group to be greater than the differences between two people from different racial/ethnic groups. Within-group variations in how individuals interact with their environments and specific social contexts are also often present.

As with all patients, it is vital to actively listen and critically evaluate patient relationships. All practitioners should seek to educate themselves regarding the experiences of patients who are members of a community that differs from their own. Resources and opportunities to collaborate may be available from community organizations and leaders.

Finally, preferred language and immigration/migration status, if the patient is comfortable providing the information, should be considered. Interpreters should be used when appropriate, with adherence to best practices for the use of interpretation services. Stressing confidentiality and privacy is particularly important for undocumented workers or recent immigrants, who may be fearful of deportation.

Black Patients

"Black" or "African American" is a classification that serves as a descriptor; it has sociopolitical and self-identification ramifications. The U.S. Census Bureau defines Black or African American as "a person having origins in any of the Black racial groups of Africa" [38].

According to the Pew Research Center, in 2023 an estimated 48.3 million individuals self-identified as Black or African American, including more than 5 million self-identified Black individuals that indicated being born in a country other than the United States [39]. This group tends to be young; 30% of the Black or African American population in the United States is younger than 20 years of age. In 2023, the median age for this group was 32.6 years, compared with the general U.S. population median age of 38.2 years [39]. In terms of educational attainment, 90.1% of Black or African American individuals had a high school diploma or equivalent and 27.6% had a bachelor's degree [40]. Geographically, more than 56% of the United States Black or African American population lives in the South, with the largest population of individuals residing in Texas (3.7 million), Florida (4.0 million), and Georgia (3.7 million) [39].

Historical adversity and institutional racism contribute to health disparities in this group. For the Black population, patient assessment and treatment planning should be framed in a context that recognizes the totality of life experiences faced by patients. In many cases, particularly in the provision of mental health care, equality is sought in the provider-patient relationship, with less distance and more disclosing.

Practitioners should assess whether their practices connect with core values of Black culture, such as family, kinship, community, and spirituality. Generalized or Eurocentric treatment approaches may not easily align with these components of the Black community [42]. Providers should also consider the impact of racial discrimination on health and mental health among Black patients. Reports indicate that expressions of emotion by Black patients tend to be negatively misunderstood or dismissed; this reflects implicit or explicit biases.

Asian Patients

"Asian" is a single term widely used to describe individuals who have kinship and identity ties to Asia, including the Far East, Southeast Asia, and the Indian subcontinent. This encompasses countries such as China, Japan, Korea, Vietnam, Cambodia, Thailand, India, Pakistan, and the Philippines. Native Hawaiian and Pacific Islander are often combined with Asian American in census data. The Pacific Islands include Hawaii, Guam, Samoa, Fiji, and many others. There are more than 25 Asian/Pacific Islander groups, each with a different migration history and widely varying sociopolitical environments in their homelands [38].

As of 2022, 24.7 million individuals in the United States identified as Asian [43]. Individuals of Chinese (excluding Taiwanese) descent represent the largest Asian subgroup in the United States (5.5 million), followed by Asian Indian (4.9 million), Filipino (4.5 million), Vietnamese (2.3 million), Korean (2.1 million), and Japanese (1.6 million) [43]. In terms of educational attainment, 92.3% of Asian individuals in the United States had a high school diploma or equivalency, and 59.3% had a bachelor's degree in 2022 [40; 43]. Geographically, individuals of Asian descent live in all regions of the United States, although the majority of individuals (55%) were located within just five states in 2019. Among Asian individuals in the United States, 6.7 million (30%) reside in California, followed by New York (1.9 million), Texas (1.6 million), New Jersey (958,000), and Washington (852,000) [44].

Asian American groups have differing levels of acculturation, lengths of residency in the United States, languages, English-speaking proficiency, education attainment, socioeconomic statuses, and religions. For example, there are approximately 32 different languages spoken among Asian individuals, and within each Asian subgroup (e.g., Chinese), multiple dialects may be present [36].

Recommended best practices when caring for Asian American patients include:

- Create an advisory committee using representatives from the community.
- Incorporate cultural knowledge and maintain flexible attitudes.
- Provide services in the patients' primary language.
- Develop culturally specific questionnaires for intake to capture information that may be missed by standard questionnaires.
- Emphasize traditional values and incorporate traditional practices (e.g., acupuncture) into treatment plans, when appropriate and desired.
- Explore patient coping mechanisms that draw upon cultural strengths.

Latino/a/x or Hispanic Patients

In 2022, the Hispanic population in the United States included 63.7 million individuals, or 19.1% of the U.S. population [45]. In 2021, 37.2 million individuals in the U.S. Hispanic population group identified as being of Mexican descent (58.4%), followed by Puerto Rican (9.1%), Salvadoran (3.9%), Dominican (3.8%), and Cuban (3.8%) [46]. They are a young group, with a median age of 30.7 years [45]. In terms of educational attainment, 75.2% of Hispanic individuals in the United States had a high school diploma or equivalency, and 20.9% had a bachelor's degree in 2022 [46]. Geographically, among the 63.7 million Hispanic individuals in the United States, 25% reside in California, followed by Texas (19%), Florida (9%), New York (6%), and Arizona (4%) [47].

When involved in the care of Latinx/Hispanic individuals, practitioners should strive to employ *personalismo* (warm, genuine communication) and recognize the importance of *familismo* (the centrality of the family). More flexible scheduling strategies may be more successful with this group, if possible, and some patients may benefit from culturally specific treatment and ethnic and gender matching with providers. Aspects of Latino culture can be assets in treatment: strength, perseverance, flexibility, and an ability to survive [36].

American Indian/Alaska Natives (AI/AN)

The American Indian/Alaska Native (AI/AN) population is extremely diverse. According to the U.S. Census, the terms "American Indian" or "Alaskan Native" refer to individuals who identify themselves with tribal attachment to indigenous groups of North and South America. Other terms used include "Native American" or "Native," although individual preference on how a person or group would like to be identified should be taken into consideration [38; 40]. In the United States, there are 574 federally recognized tribal governments and 324 federally recognized reservations [57].

In 2020, it was reported that there were 9.7 million AI/AN individuals in the United States. In general, this group is young, with a median age of 31 years, compared with the general median age of 38.2 years [57]. In terms of education attainment, 74% of AI/AN individuals in the United States had a high school diploma or equivalency, and 16.8% had a bachelor's degree in 2023 [40; 41]. As of 2020, the states with the greatest number of residents identifying as American Indian are California (11.7%), Oklahoma (11.7%), Arizona (9.5%), New Mexico (9.1%), , and Texas (5.9%). Alaska Native individuals make up 67.1% of the population in Alaska [58].

Listening is an important aspect of rapport building with AI/AN patients, and practitioners should use active listening and reflective responses. Assessments and histories may include information regarding patients' stories, experiences, dreams, and rituals and their relevance. Interruptions and excessive questioning should be avoided if at all possible. Extended periods of silence may occur, and time should be allowed for patients to adjust and process information. Practitioners should avoid asking about family or personal matters unrelated to presenting issues without first asking permission to inquire about these areas. Native American/Alaska Native patients often respond best when they are given suggestions and options rather than directions [36].

White American Patients

In 2023, 75.3% of the U.S. population identified as White alone [48]. The U.S. Census Bureau defines White race as person having origins in any of the original peoples of Europe, the Middle East, or North Africa [38]. The White population in the United States is diverse in its religious, cultural, and social composition. The greatest proportion of this group reports a English ancestry (25.5 million), followed by Irish (10.9 million), German (15.4 million), and Italian (6.6 million) [49]. The median age of White individuals is 44 years. In terms of education attainment, 95.2% of White-only individuals in the United States had a high school diploma or equivalency, and 41.8% had a bachelor's degree in 2022 [40]

Providers can assume that most well-accepted treatment approaches and interventions have been tested and evaluated with White American individuals, particularly men. However, approaches may need modification to suit class, ethnic, religious, and other factors [36].

Providers should establish not only the patient's ethnic background, but also how strongly the person identifies with that background. It is also important to be sensitive to multiracial/multiethnic heritage, if present, and how this might affect family relationships and social experiences. Assumption of White race should be avoided, as White-passing persons of color have their own unique needs [36].

RELIGIOUS, CULTURAL, AND ETHNIC BACKGROUNDS

Religion, culture, beliefs, and ethnic customs can influence how patients understand health concepts, how they take care of their health, and how they make decisions related to their health. Without proper training, clinicians may deliver medical advice without understanding how health beliefs and cultural practices influence the way that advice is received. Asking about patients' religions, cultures, and ethnic customs can help clinicians engage patients so that, together, they can devise treatment plans that are consistent with the patients' values [37].

Respectfully ask patients about their health beliefs and customs and note their responses in their medical records. Address patients' cultural values specifically in the context of their health care. For example, one may ask [37]:

- "Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?"
- "Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight?"
- "Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to talk to about your condition?"
- "What do you call your illness and what do you think caused it?"
- "Do any traditional healers advise you about your health?"

Practitioners should avoid stereotyping based on religious or cultural background. Each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Asking patients about their beliefs and way of life is the best way to be sure you know how their values may impact their care [37].

GENDER

The term "gender" refers to the established and expected norms, behaviors, and roles associated with being a girl, boy, woman, or man. Because gender is a social construct, the definition of gender is unique to any given society and/or collective group and changes over time. Gender is hierarchical and produces inequalities that often intersect with one or more social and/or economic inequalities. Other important terms related to gender include [50; 51]:

Gender identity: A person's internal identification and experience of gender, which may or may not correspond to physiology or designated sex at birth. Gender identities include cisgender (identify as sex assigned at birth), transgender (identify as a different sex than assigned at birth), and non-binary (do not identify as either male or female), among others.

Gender expression: The way in which an individual expresses gender outwardly through appearance (e.g., clothing, make up, physical features), behaviors, and personality styles, often culturally defined as masculine or feminine. Gender expression can, but does not always, reflect the person's gender identity; individual preference, comfortability, culture, and societal and sociopolitical acceptance can influence gender expression.

Gender role: A set of societal expectations about how someone should behave based on their gender, often categorized as masculine or feminine.

Sex: The biological and physiological characteristics that differentiate male and female, such as chromosomes, hormones, and reproductive organs. The terms "sex" and "gender" are often incorrectly used interchangeably; however, it is important to differentiate between the two and be able to identify that sex is biological and gender is a social construct.

Gender traits and roles common for men in Western societies are often related to views of masculinity, and include an emphasis on strength, courage, leadership, independence, dominance, and assertiveness. Issues related to male gender identity, including inadequate help-seeking, denial of pain and weakness, and not showing emotion, have several important implications for health. Research has shown that male gender identity has been associated with risky behavior and an increased risk for negative health consequences, including injury, disease, and death [53; 54; 55].

Gender roles among women are related to femininity and include being polite, accommodating, nurturing, passive, and helpful. Women are often viewed as caregivers and tend to prioritize the needs of others above personal needs. In addition, providing gender-sensitive care to women involves overcoming the limitations imposed by the dominant medical model in women's health, improving advocacy for oneself [53].

In addition, the concept of masculinity may lead to inadequate help- and information-seeking behavior and a reduced likelihood of engaging in behavior to promote health. These behaviors appear to be rooted in a decreased likelihood for men to perceive themselves as being ill or at risk for illness, injury, or death [53; 54; 55]. Although men are more likely than women to lack a regular healthcare provider and to avoid seeking help or information, women are more likely to have a chronic condition requiring regular monitoring and are more likely to have forgone necessary health care and/or medication due to the cost [53].

Men's beliefs about masculinity and traditional male roles affect health communication and literacy, and healthcare practitioners should consider male-specific beliefs and perceptions when communicating with male patients. For example, because men tend to focus on present rather than future health, concepts of fear, wellness, and longevity often do not work well in health messages. Instead, healthcare practitioners should focus more on "masculine" concepts, such as strength, safety, and performance, all of which tie into men's perceptions of their roles as providers and protectors [54; 55]. Women tend to have a higher level of health literacy but should still be involved and active participant with their own healthcare and/or treatment plans [53].

GENDER AND SEXUAL MINORITY POPULATIONS

The gender and sexual minority (GSM) population, also referred to as the transgender and gender nonconforming population, is a diverse group that can be defined as a subculture, accounting for 7.6% of the U.S. population in 2023 [3]. This group includes gay men, lesbian women, bisexual persons, transgender individuals, and those questioning their sexual identity, among others. The GSM population is diverse, representing all ages and all socioeconomic, ethnic, educational, and religious backgrounds. The population has been described as "hidden and invisible," "marginalized," and "stigmatized." As a result, the unique health and safety needs of the population have often been overlooked or ignored. Clear definitions of the concepts related to sexual identity will be helpful. The following is a glossary of terms used in discussions of this group [50; 51; 52]:

Asexual/aromantic: An individual who does not experience sexual attraction. There is considerable diversity in individuals' desire (or lack thereof) for romantic or other relationships.

Bisexual: An adjective that refers to people who relate sexually and affectionately to both women and men.

Coming-out process: A process by which an individual, in the face of societal stigma, moves from denial to acknowledging his/her sexual orientation. Successful resolution leads to self-acceptance. Coming out is a lifelong process for lesbian, gay, bisexual, and transgender persons and their families and friends as they begin to tell others at work, in school, at church, and in their communities.

Gay: The umbrella term for GSM persons, although it most specifically refers to men who are attracted to and love men. It is equally acceptable and more accurate to refer to gay women as "lesbians."

Gender and sexual minorities (GSM): A term meant to encompass lesbian, gay, bisexual, trans, queer/questioning, intersex/intergender, asexual/ally (LGBTQIA+) people as well as less well-recognized groups, including aromantic, two-spirited, and gender-fluid persons.

Heterosexism: An institutional and societal reinforcement of heterosexuality as the privileged and powerful norm.

Heterosexuality: Erotic feelings, attitudes, values, attraction, arousal, and/or physical contact with partners of the opposite gender.

Homophobia: A negative attitude or fear of non-straight sexuality or GSM individuals. This may be internalized in the form of negative feelings toward oneself and self-hatred. Called "internalized homophobia," it may be manifested by fear of discovery, denial, or discomfort with being LGBTQIA+, low self-esteem, or aggression against other lesbians and gay men.

Homosexuality: The "persistent sexual and emotional attraction to members of one's own gender" as part of the continuum of sexual expression. Typically not used to describe people.

Intersex/intergender: Encompasses a diverse set of congenital differences relating to gonads, chromosomes, and genitals that fall outside the typical parameters of male or female sex. Although intersex falls under the umbrella of LGBTQIA+, many do not identify with that label.

LGBTQIA+: An acronym used to refer to the lesbian, gay, bisexual, transgender/transsexual, queer/questioning, intersex/intergender, asexual/ally community. In some cases, the acronym may be shortened for ease of use, although a + usually always follows to represent other identities not included in the other letters.

Queer: An umbrella term to describe persons with a spectrum of identities and orientations that are outside of the heteronormative standard.

Sexual identity: The inner sense of oneself as a sexual being, including how one identifies in terms of gender and sexual orientation.

Sexual orientation: An enduring emotional, romantic, sexual, and/or affectionate attraction to another person. Individuals may experience this attraction to someone of the same gender, the opposite gender, both genders, or gender-nonconforming.

Transgender: An umbrella term describing a number of distinct gender positions and identities, including crossdressing, transsexual, non-binary, and intersex.

One's intrapersonal acceptance or rejection of societal stereotypes and prejudices, the acceptance of one's self-identity as a sexual minority, and how much one affiliates with other members of the GSM community varies greatly among individuals. Some authors stress the diversity within the GSM community by discussing "GSM populations." For example, it is understandable that a GSM population living in rural areas of the United States would have little in common with a GSM population living in urban areas or "gay-friendly" neighborhoods. Additionally, mental health experts have suggested that "GSM community" symbolizes a single group of individuals who express their sexuality differently than the majority of heterosexual individuals. However, many distinct communities have been identified, including lesbian, gay, bisexual, and transgender.

Each community is different from the other as well as different from the heterosexual community. A culturally competent healthcare provider should keep this diversity in mind so that vital differences among these smaller groups are not lost when thinking of the GSM population in general [50; 51; 56].

Commonalities exist among the GSM communities as well. For example, many adolescents, whether gay, lesbian, bisexual, transgender, or questioning their sexual identity, lack sexual minority role models to assist with successful psychosocial development [51; 56].

The subtle and pervasive ways that discomfort with GSM individuals may be manifested have been examined and, in some instances, categorized as "cultural heterosexism," which is characterized by the stigmatization in thinking and actions found in our nation's cultural institutions, such as the educational and legal systems. "Cultural heterosexism fosters individual antigay attitudes by providing a ready-made system of values and stereotypical beliefs that justify such prejudice as natural" [59]. Perhaps the paucity of information about the GSM community in basic professional education has been a reflection of cultural heterosexism. Writers, funding sources, and publishers have been exposed to the same cultural institutions for many years [56].

Individuals generally begin to absorb these institutional attitudes as children and may consequently develop "psychological heterosexism," which may also manifest as antigay prejudice. Many individuals, as children, have little contact with someone who is openly gay and, as a result, may not be able to associate homosexuality with an actual person. Instead, they may associate it with concepts such as "sin," "sickness," "predator," "outsider," or some other negative characteristic from which the individual wants to maintain distance [59]. Psychological heterosexism involves (among other factors) considering sexual identity and determining that one does not want to think further about it. The direction of this thinking is undeniably negative, resulting in an environment that allows antigay hostility [59]. The impact of antigay prejudice on the physical and mental health of members of the LGBTQIA+ community and their families should not be underestimated.

Sexual minority individuals also are not immune to societal attitudes and may internalize negative aspects of the antigay prejudice experience. Anxiety, depression, social withdrawal, and other reactions may result. While the study of psychological heterosexism, both blatant and subtle, is in the early stages of research, it has had a measurable impact on the mental health of the GSM community [2; 51; 56; 69; 70].

Examples of the range of manifestations of heterosexism and/or homophobia in our society are readily available. Without difficulty, each example presented here may be conceptualized as related to the emotional or physical health of a GSM individual or family member:

- A kindergarten student calls another child an LGBTQIA+ slur but does not really know what he is saying.
- A teenage girl allows herself to become pregnant, "proving" her heterosexuality to herself, her family, and her friends.
- A parent worries that her 12-year-old daughter is still a "tomboy."
- An office employee decides to place a photo of an old boyfriend in her office rather than a photo of her gender-nonconforming partner of five years.
- A college student buries himself in his studies in an effort to ignore his same-sex feelings and replace feelings of isolation.
- Two teenage girls, thought by peers to be transgender individuals, are assaulted and killed while sitting together in an automobile.

- A female patient is told by a healthcare provider that her haircut makes her look like a lesbian and is examined roughly.
- A gay man chooses not to reveal his sexual identity to his healthcare provider out of fear of a reduction or withdrawal of healthcare services.

The manifestations of heterosexism have inhibited our learning about the LGBTQIA+ population and its needs. Gay patients have feared open discussion about their health needs because of potential negative reactions to their self-disclosure. Prejudice has impacted research efforts by limiting available funding. All of these factors emphasize that the healthcare education system has failed to educate providers and researchers about the unique aspects of LGBTQIA+ health [56].

Common Myths

Many myths surround homosexuality; a few are outlined below. The origin of these myths may be better understood after examining the history of homosexuality as well as the attitudes toward human sexuality in general. The history of the development of societal norms related to homosexuality includes misconceptions developed during times when research was not available on which to build a scientific knowledge base [71; 72; 73].

Myth: Sexual orientation is a choice.

Fact: No consensus exists among scientists about the reasons that an individual develops his/her sexual orientation. Some research has shown that the bodies and brains of gay men and women differ subtly in structure and function from their heterosexual counterparts; however, no findings have conclusively shown that sexual orientation is determined by any particular factor or set of factors. Many people confuse sexual orientation with sexual identity. The reader may consider reviewing the definitions of these terms when further considering this myth.

Myth: Gay men and lesbians can be easily identified because they have distinctive characteristics.

Fact: Most gay and lesbian individuals conform to the majority of society in the way they dress and act. Further, a person's appearance is not necessarily an indication of sexual or romantic interests.

Myth: Gay people want to come into our schools and recruit our children to their "lifestyle."

Fact: Efforts to bring issues related to LGBTQIA+ history and rights into schools are not efforts to "convert," just as education on European history is not an effort to glamorize or "convert" to European identity. The intent has been to teach a more complete history of the world and to prevent children from mistreating LGBTQIA+ who are often the subjects of harassment and physical attacks. There is no evidence that people could be "recruited" to a gay sexual orientation, even if someone wanted to do this.

AGE

Elderly patients should be routinely screened for health and mental health conditions using tools specifically developed for this population, despite some practitioners' discomfort with asking questions about sensitive topics. These population-appropriate assessments may be included in other health screening tools.

An emphasis on wellness and purpose is important when working with older adults. In the past, aging was associated with disability, loss, decline, and a separation from occupational productivity. Although patient growth and positive change and development are values that practitioners embrace, the unconscious acceptance of societal myths and stereotypes of aging may prevent practitioners from promoting these values in elderly individuals [74; 77].

Common Myths of Aging

Society holds several myths about the elderly. Many of these myths may be easily disputed based on existing demographic survey data and other studies.

Myth: Most older adults live alone and are isolated.

Fact: In 2023, 68% of men and 47% of women 65 years and older were married. An estimated 28% lived alone [75]. In 2021, an estimated 18% of the U.S. population lived in multigenerational household, compared with 7% in the early 1970s. Several factors have contributed to this trend, including growing racial and ethnic diversity, financial reasons, and caregiving Individuals 65 years and older comprise nearly 20% of individuals living in multigenerational households [76].

Myth: Most older adults engage in very minimal productive activity.

Fact: In 2023, 19% of persons 65 years and older were employed or actively looking for work, representing approximately 7% of all wages and salaries paid by U.S. employers. The elderly are more engaged in self-employed activities than younger persons. In 2023, 23% of those 65 years of age and older were self-employed, compared with an average of 10% of those 25 years to 64 years of age [78].

Myth: Life satisfaction is low among the elderly.

Fact: Data from a 2024 survey conducted by the AARP indicate that 9 out of 10 individuals 50 years of age and older are at least somewhat optimistic about their future, with half (49%) being extremely or very optimistic. Approximately 25% of respondents 65 years of age and older reported being very happy, compared to 17% in those 50 to 64 years of age. Most of the factors that predict happiness for the young, such as good health and financial stability, also apply to the elderly. Older adults tend to report higher levels of well-being in part due to the quality of their social relationships; 28% indicate their relationships with friends and family have improved in the last five years, and 45% feel they will continue to get better [79].

PERSONS WITH MENTAL OR PHYSICAL DISABILITY

Americans with disabilities represent a large and heterogeneous segment of the population. The prevalence of disability varies by age group and definition. Based on the U.S. Census Bureau's 2023 American Community Survey (ACS), which describes disability in terms of functional limitations, 13.6% of the civilian U.S. noninstitutionalized population has a disability, defined as difficulty in hearing or vision, cognitive function, ambulation, self-care, or independent living [80]. Among individuals 3 to 21 years of age in the 2022–2023 school year, 15% of those enrolled in public school had a disability (defined as specific learning disabilities, speech or language impairments, intellectual disability, emotional disturbance, hearing impairments, orthopedic impairments, other health impairments, visual impairments, multiple disabilities, deaf-blindness, autism, traumatic brain injury, or developmental delay) [81].

People with disabilities experience many health disparities. Some documented disparities include poorer self-rated health; higher rates of obesity, smoking, and inactivity; fewer cancer screenings (particularly mammography and Pap tests); fewer breast-conserving surgeries when breast cancer is diagnosed; and higher rates of death from breast or lung cancer [82].

Disability cultural competence requires appreciation of social model precepts, which recognize patients' rights to seek care that meets their expectations and values. The social model of disability has been characterized as centering disability as a social creation rather than an attribute of the patient. As such, disability requires a social/political response in order to improve environmental factors affecting access and acceptance [83]. This involves adoption of person-first language, acknowledgement of social and environmental factors impacting persons abilities, and confronting disability-associated stigma.

VETERANS

The effects of military service and deployment to military combat on the individual and the family system are wide-reaching. According to the U.S. Department of Defense, there were 3.4 million current military personnel in 2023 and 15.8 million veterans in 2023 [106; 107]. The Army has the largest number of active-duty members, followed by the Navy, Air Force, and Marine Corps [106]. Military service presents its own set of risk and protective factors for a variety of mental health issues, including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression and suicide, substance abuse, and interpersonal violence. In particular, transitioning from combat back to home life can be particularly trying for veterans and their families.

As the number of military conflicts and deployments has increased since 2001, the need to identify and provide better treatment for veterans and their families has become a greater priority. The first step in providing optimal care is the identification of veterans and veteran families during initial assessments, with an acknowledgement that veterans may be any sex/gender and are present in all adult age groups.

Unfortunately, veterans and military families often do not voluntarily report their military service in healthcare appointments. In 2015, the American Medical Association updated its recommendations for social history taking to include military history and veteran status [108]. In addition, the American Academy of Nursing has designed the Have You Ever Served? Initiative to encourage health and mental health professionals to ask their patients about military service and related areas of concern [109]. This program provides pocket cards, posters, and resource links for professionals working with veterans and their families. Recommended questions for intake include [109]:

- Have you or has someone close to you ever served in the military?
- When did you serve?
- Which branch?
- What did you do while you were in the military?
- Were you assigned to a hostile or combative area?
- Did you experience enemy fire, see combat, or witness casualties?
- Were you wounded, injured, or hospitalized?
- Did you participate in any experimental projects or tests?
- Were you exposed to noise, chemicals, gases, demolition of munitions, pesticides, or other hazardous substances?

PROMOTING CULTURALLY SENSITIVE COMMUNICATION

Communication, the process of sending a message from one party to another, consists of both verbal and nonverbal components. Verbal and nonverbal communications are embedded within the culture of the parties disseminating the information and within the culture of the parties receiving the information. Communication is complex and multilayered because it involves unstated, implicit rules about a variety of factors, including physical distance between parties, tone of voice, acceptable topics of discussion, physical contact, and amount of eye contact [84]. Each of these variables is influenced by the perception of the level of formality/informality of the situation. Frequently, misunderstandings occur because the decoding and interpretation of these nonverbal cues are not accurate.

The verbal component of communication is just as complicated. Certainly, similarity in language shared by both parties enhances communication, but assuming that both parties in a conversation speak the same language, how the information is interpreted is still influenced by a host of factors. Linguists have posited that approximately 14,000 different meanings and interpretations can be extracted from the 500 most common English words [85].

Consequently, practitioners must be aware of the different communication styles held by diverse ethnic minority patients, as the clinical communication process is the primary vehicle by which problems and solutions are identified and conveyed [86].

Styles of communication can be classified from high- to low-context [87]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [85; 88]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [84; 87]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in the conversation [85]. Consequently, low-context communicators listen with their ears and focus on what is being said [84; 87; 88]. Western culture, including the United States, can be classified as a low-context culture. On the other hand, groups from collectivistic cultures, such as Asian/Pacific Islander, Hispanic, AI/AN, and Black and African American, are from high-context cultures [87].

Communicators from high-context cultures generally display the following characteristics [84; 85; 88]:

- Use of indirect modes of communication
- Use of vague descriptions
- Less talk and less eye contact
- Interpersonal sensitivity
- Use of feelings to facilitate behavior
- Assumed recollection of shared experiences
- Reliance on nonverbal cues such as gestures, tone of voice, posture, voice level, rhythm of speaking, emotions, and pace and timing of speech
- Assimilation of the "whole" picture, including visual and auditory cues
- Emotional speech
- Use of silence
- Use of more formal language, emphasizing hierarchy between parties

On the other hand, low-context communicators can typically be described as [84; 85; 88]:

- Employing direct patterns of communication
- Using explicit descriptions and terms
- Assuming meanings are described explicitly
- Utilizing and relying minimally on nonverbal cues
- Speaking more and often raising their voices (more animated, dramatic)
- Often being impatient to get to the point of the discussion
- Using more informal language; less emphasis on hierarchy, more equality between parties (more friendly)
- Being more comfortable with fluidness and change
- Uncomfortable using long pauses and storytelling as a means of communicating

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture (e.g., low-context culture) will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. A Chinese American man may not necessarily be a high-context communicator because he is Asian. A host of factors, such as level of acculturation, upbringing and socialization, education, and family immigration history, will all play a role in how one learns to communicate. Third, a major criticism of the discussion of low-/high-context cultures is that they reinforce dualism and ultimately oversimplify the complexities and nuances of communication [89].

Learning to communicate effectively also requires an understanding of how different conversational traits influence the communication process, or how information is conveyed and interpreted. Again, the goal of this section is not to simply dichotomize individuals' conversational styles into categories, but rather to understand the factors that play a role in how someone makes a decision on how to communicate [84].

As long as there are two parties involved in a conversation, nonverbal communication is inevitable, and it becomes salient particularly when it is processed from one culture to another. Nonverbal communication is any behavior (including gestures, posture, eye contact, facial expressions, and body positions) that transcends verbal or written forms of communication [90]. Nonverbal communication can enhance or reinforce what is said verbally, and conversely, it can completely contradict the message communicated verbally. It can also end up replacing what was verbally communicated if both parties do not share a native language [91].

In Western culture, communication is more direct and eye contact is highly valued. When eye contact is not maintained, many Westerners assume that the party is hiding pertinent information. However, in some cultures, reducing eye contact is a sign of respect [86]. Conversely, patients may interpret direct and indirect gazes differently. For example, in one study, Japanese individuals tended to rate faces with a direct gaze as angry and less pleasant compared with Finnish participants [92].

The amount of social space or distance between two communicating parties is culturally charged as well. Depending upon the social context, Westerners tend to maintain a distance of about three feet, or an arm's length, in conversations [85]. In a public setting, where both parties are engaged in a neutral, nonpersonal topic, Westerners will feel encroached upon and uncomfortable if an individual maintains a closer conversational distance. However, in other cultures, such as Latino and Middle Eastern, a closer distance would be the norm [85]. Chung recommends that in a clinical setting the practitioner allow patients to set the tone and social distance [93]. The practitioner can sit first and permit the patient to select where they want to sit.

Cross-cultural communication is by no means simple, and there is no set of rules to merely abide by. Instead, promoting culturally sensitive communication is an art that requires practitioners to self-reflect, be self-aware, and be willing to learn. Therefore, as practitioners become skilled in noticing nonverbal behaviors and how they relate to their own behaviors and emotions, they will be more able to understand their own level of discomfort and comprehend behavior from a cultural perspective [84].

CULTURALLY SENSITIVE ASSESSMENT GUIDELINES

Practitioners may be categorized as either disease-centric or patient-centric [94]. Disease-centered practitioners are concerned with sign/symptom observation and, ultimately, diagnosis. On the other hand, patient-centered practitioners focus more on the patient's experience of the illness, subjective descriptions, and personal beliefs [94]. Patient-centered practice involves culturally sensitive assessment. It allows practitioners to move assessment and practice away from a pathology-oriented model and instead acknowledge the complex transactions of the individual's movement within, among, and between various systems [95].

Practitioners who engage in culturally sensitive assessment nonjudgmentally obtain information related to the patient's cultural beliefs, overall perspective, and specific health beliefs [96]. They also allow the patient to control the timing [97].

The goal is to avoid the tendency to misinterpret health concerns of ethnic minority patients. Panos and Panos have developed a qualitative culturally sensitive assessment process that focuses on several domains [96]. Each domain includes several questions a practitioner may address in order to ensure that he or she is providing culturally responsive care.

Alternatively, Kleinman suggests that the practitioner ask the patient what he or she thinks is the nature of the problem. He highlights the following types of questions that may be posed to the patient [98]:

- Why has the illness/problem affected you?
- Why has the illness had its onset now?
- What course do you think the illness will follow?
- How does the illness affect you?
- What do you think is the best or appropriate treatment? What treatment do you want?
- What do you fear most about the illness and its treatment?

Similar to Kleinman's culturally sensitive assessment questions, Galanti has proposed the 4 Cs of Culture [99]:

- What do you call the problem?
- What do you think caused it?
- How do you cope with the problem?
- What questions or concerns do you have about the problem or treatment?

Pachter proposed a dynamic model that involves several tiers and transactions, similar to Panos and Panos' model [100]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional must be willing to acknowledge that they do not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups they come in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [100]. Pachter advocates the notion that there is tremendous diversity within groups. Often, there are many intersecting variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the patient and the professional [100]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. The professional might recommend a combination of alternative and Western treatments.

Beckerman and Corbett further recommend that recently immigrated families be assessed for [101]:

- Coping and adaptation strengths
- Issues of loss and adaptation
- The structure of the family in terms of boundaries and hierarchies after immigration
- Specific emotional needs
- Acculturative stress and conflict for each family member

Practitioners should seek to understand the sociopolitical context of the origin country. A migration narrative is also recommended, whereby an individual provides a story of their migration history. Asking about how long the family has been in the United States, who immigrated first, who was left behind, and what support networks are lacking gives the practitioner an overview of the individual's present situation. The theme of loss is very important to explore. Types of losses may include family and friends left behind, social status, social identity, financial resources, and familiarity. For refugees and newly immigrated individuals and families, assessment of basic needs (e.g., food, housing, transportation) is necessary [102; 103].

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. Practitioners should work to recognize that there are a host of factors that contribute to patients' multiple identities (e.g., race, gender, socioeconomic status, religion) [36; 37; 82].

A WELCOMING AND SAFE ENVIRONMENT

Improving access to care can be facilitated, in part, by providing a welcoming environment. The basis of establishing a safe and welcoming environment for all patients is security, which begins with inclusive practice and good clinician-patient rapport. Shared respect is critical to a patient's feeling of psychological well-being. Security can also be fostered by a positive and safe physical setting. For patients who are acutely ill, both the illness experience and treatment process can produce trauma. This is particularly true if involuntary detainment or hospitalization is necessary, but exposure to other individuals' narratives of experienced trauma or observing atypical behaviors from individuals presenting as violent, disorganized, or harmful to themselves can also be traumatic. As such, care environments should be controlled in a way to minimize traumatic stress responses. Providers should keep this in mind when structuring the environment (e.g., lighting, arrangement of space), creating processes (e.g., layout of appointments or care systems, forms), and providing staff guidance (e.g., nonverbal communication, intonation, communication patterns). During each encounter, the patient's perception of safety is impacted by caretakers and ancillary staff [36; 82].

Experts recommend the adoption and posting of a nondiscrimination policy that signals to both healthcare providers and patients that all persons will be treated with dignity and respect. Also, checklists and records should include options for the patient defining their race/ethnicity, preferred language, gender expression, and pronouns; this can help to better capture information about patients and be a sign of acceptance to that person. If appropriate, providers should admit their lack of experience with patient subgroups and seek guidance from patients regarding their expectations of the visit [36; 51; 53].

Front office staff should avoid discriminatory language and behaviors. For example, staff should avoid using gender-based pronouns, both on the phone and in person. Instead of asking, "How may I help you, sir?" the staff person could simply ask, "How may I help you?" Offices that utilize electronic health records should have a system to track and record the gender, name, and pronoun of all patients. This can be accomplished by standardizing the notes field to document a preferred name and pronoun for all patients. Some persons who identify as non-binary (i.e., neither or both genders) may prefer that plural pronouns (e.g., they) be used [36; 51].

Questions should be framed in ways that do not make assumptions about a patient's culture, gender identity, sexual orientation, or behavior. Language should be inclusive, allowing the patient to decide when and what to disclose. Assurance of confidentiality should be stressed to the patient to allow for a more open discussion, and confidentiality should be ensured if a patient is being referred to a different healthcare provider. Asking open-ended questions can be helpful during a history and physical [36; 51; 82].

The FACT acronym may be helpful for healthcare providers. Providers should:

- Focus on those health issues for which the individual seeks care
- Avoid intrusive behavior
- Consider people as individuals
- Treat individuals according to their gender

Training office staff to increase their knowledge and sensitivity toward persons will also help facilitate a positive experience for patients.

CONCLUSION

Culture serves as a lens through which patients and practitioners filter their experiences and perceptions. Patients will bring their unique life stories and concerns to the practitioner, and their cultural values and belief systems will inevitably shape how the problem is defined and their beliefs about what is effective in solving the problem. However, the cultural backgrounds and values of patients are not necessarily scripts that define behavior, and when practitioners view culture as a strength and not a pathology, practitioners will be able to more effectively join with patients to mobilize change.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

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