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Critical elements of culturally competent communication in the medical encounter: A review and model[☆]

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A B S T R A C T

Keywords:

Cultural competence
Patient–physician communication
Physician education
USA

Increasing the cultural competence of physicians is one means of responding to demographic changes in the USA, as well as reducing health disparities. However, in spite of the development and implementation of cultural competence training programs, little is known about the ways cultural competence manifests itself in medical encounters. This paper will present a model of culturally competent communication that offers a framework of studying cultural competence 'in action.' First, we describe four critical elements of culturally competent communication in the medical encounter – communication repertoire, situational awareness, adaptability, and knowledge about core cultural issues. We present a model of culturally competent physician communication that integrates existing frameworks for cultural competence in patient care with models of effective patient-centered communication. The culturally competent communication model includes five communication skills that are depicted as elements of a set in which acquisition of more skills corresponds to increasing complexity and culturally competent communication. The culturally competent communication model utilizes each of the four critical elements to fully develop each skill and apply increasingly sophisticated, contextually appropriate communication behaviors to engage with culturally different patients in complex interactions. It is designed to foster maximum physician sensitivity to cultural variation in patients as the foundation of physician-communication competence in interacting with patients.

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Introduction

Training programs for physician cultural competence (CC) hold communication as central to a successful medical encounter between physicians and patients. Betancourt *et al.* have suggested that cultural differences between the physician and patient can serve as a barrier to effective communication, with undesired products of patient

dissatisfaction, poor adherence, and adverse health outcomes (Betancourt, Green, Carrillo, & Park, 2005; Carrillo, Green, & Betancourt, 1999). A culturally competent physician has the capacity to recognize and reconcile socio-cultural differences between the physician and the patient in order to have a more patient-centered approach to care (Saha, Arbelaez, & Cooper, 2003). Patient-centered communication has been linked to improved health outcomes (Epstein & Street, 2007; Mead & Bower, 2002) and is characterized by communication that elicits and understands the patient's perspective and social context, reaches a shared understanding of the problem and its treatment, and involves patients in choices to the extent they desire (Aita, McIlvain, Backer, McVea, & Crabtree, 2005; Epstein *et al.*, 2005; Stewart, 1995). Patient-centered

[☆] This work was supported by the Centers for Disease Control (K01 DP000090) and by the Houston VA HSR&D Center of Excellence (HFP90-020). The authors wish to thank Dr Paul Haidet for early reviews of this manuscript.

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care and culturally competent care share many aspects, but differ in focus. Patient-centered care emphasizes improving high-quality individualized care for all patients, while culturally competent care stresses equitable distribution of quality care among diverse and disadvantaged groups (Beach, Saha, & Cooper, 2006). The medical encounter is a critical point where health disparities may originate (Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006), and increasing the CC of physicians may help reduce such disparities (Betancourt, Green, Carrillo, & Ananeh-Firemong, 2003; Brach & Fraser, 2000; Cooper, 2004; Institute of Medicine, 2002).

In this paper, we present a model of culturally competent communication (CCC) that examines physician CC within the context of specific medical encounters. At the most basic level, patient-physician encounters can be intercultural, as lay patient culture intersects with physicians' medical culture. Other cultural factors along which physicians and patients may differ, such as those potentially associated with race/ethnicity, gender, age or socio-economic status, also complicate the delivery of patient-centered care. Though many aspects of our model overlap with patient-centered communication, we believe the CCC model integrates frameworks for CC in patient care with models of effective patient-centered communication. Based upon our review of the these literatures, we describe four critical communication elements of CCC in the medical encounter – communication repertoire, situational awareness, adaptability, and knowledge about core cultural issues – that are inadequately addressed in many theoretical and educational models of CC. Second, we offer a model of culturally competent physician communication in which proficiency at applying the four critical elements is explored among five CC communication skills. The model captures the essence of CCC across the primary functions of the medical encounter, as well as offering specific behavioral markers and skills by which a culturally competent physician engages in patient-centered care.

Communication repertoire

Physicians must have skills to produce culturally appropriate communication behavior. Skills-based communication training can improve the quality of interactions with patients (Davis, Thomson, Oxman, & Haynes, 1995), which in turn affects patient outcomes (Beach et al., 2005; Stewart, 1995). Most curricular frameworks for effective cross-cultural communication, which have been summarized elsewhere (Association of American Medical Colleges, 2005), provide general guidance regarding *what* patient information should be obtained (e.g., cultural identity, explanations for and emotional implications of illness, use of alternative healers) and *how* to engage with the patient (e.g., listen, have empathy, negotiate), but offer little in the way of specific behavioral strategies for communicating effectively with patients who are culturally different than the physician (Chin, 2000). Physicians should demonstrate communication competencies for each of the three functions of the medical encounter (Cole & Bird, 2000; Lazare, Putnam, & Lipkin, 1995), which include building the relationship, information gathering and

assessment of patient problems, and managing patient problems. Physicians can develop more CC from programs that teach specific cross-cultural, skill-based communication competencies (Betancourt, 2006; Kripalani, Bussey-Jones, Katz, & Genao, 2006; Rapp, 2006).

A recent study of faculty, medical students, and patients' perceptions of CC suggested that patients identified common communication behaviors as most reflecting CC, including taking sufficient time, apologizing for being busy, answering questions, giving explanations, and acting interested in the patient (Shapiro, Hollingshead, & Morrison, 2002). Shapiro's research demonstrates that a CCC repertoire must reflect attitudes of empathy, caring, and respect that are explicitly fundamental to all care (Betancourt, 2003; Kim-Godwin, Clarke, & Barton, 2001; Kleinman & Benson, 2006), and include foundational skills such as active listening, attending to socio-cultural aspects of the illness, eliciting patient perspectives, and empowering the patient to make decisions (Buyck & Lang, 2002; Krupat, Frankel, Stein, & Irish, 2006; Makoul, 2001; Zoppi & Epstein, 2002). These communication skills are essential to building a relationship with the patient, the first function of the medical encounter, and to fostering success in the second and third functions of assessment and problem management.

Many of the skills described in this section are fundamentals of patient-centered care. However, the more strongly patients adhere to cultural group norms and embrace cultural representations of illness that differ from that of the physician, the more advanced a physician's communication skills must be both patient-centered and culturally competent. Culturally competent physicians must draw upon a diverse repertoire of communication skills to personalize their communication according to the patient's individual manifestation of cultural identity, aid the patient in building a relationship, guide assessment and management of core cultural issues, negotiate treatment decisions, and involve the patient in care to the degree that he or she wishes.

Situational- and self-awareness

CCC also requires skills of perception. Physicians with more CC cultivate *situational awareness*. They attend to patient cues and expectations and the nuances of interaction, specifically to recognize misunderstandings that are rooted in inaccurate assumptions and awkwardness due to physician-patient cultural differences. Such awareness informs communication acts aimed at resolving confusion, reconciling points of disagreement or difference, and achieving a common understanding of the health condition and treatment options (Epstein & Street, 2007). Such situational awareness likely requires physician "mindfulness" (Epstein, 2006; Zoppi & Epstein, 2002) – being attentive to the patient, curious without reliance on quick assumptions, and conveying presence in the encounter and connection to the patient.

However, few CC programs actively teach and assess physicians' situational awareness. Most emphasize a physician's self-awareness (Betancourt, 2003; Kripalani et al., 2006; Lie, Boker, & Cleveland, 2006), specifically of his/her

own cultural identity and beliefs as well as potential stereotypes or prejudices he or she might hold about particular demographic groups (Burgess, van Ryn, Crowley-Matoka, & Malat, 2006). For example, a self-aware physician might recognize his/her tendency toward negative emotional reactions to a patient belonging to specific groups (e.g., a specific race or religion) and attempt to control this emotion so that it did not influence medical decisions. If this physician was also situationally-aware, he/she would also play close attention to corresponding patient reactions, such as tone of voice, choice of words, facial expressions, or silence. This would help the physician gauge whether the potential bias was mitigated and how specific communication strategies helped or hampered the interaction.

Self-awareness is essential to CC in the medical encounter. Only a self-aware physician can completely understand his/her reactions to or expectations of a patient, judge the extent to which personally held bias might influence the situation, and attempt to manage that bias. However, physicians must also develop situational awareness to achieve CCC. Situational awareness of the patient-provider interaction permits the physician to develop a more thorough understanding of how his/her behavior may affect the patient; whether this behavior helps or hinders the interaction, and whether an adjustment in judgment and behavior might be warranted. This is especially critical in today's social milieu, in which physicians may encounter members of cultural groups to which they have not been exposed.

Adaptability

Physicians are generally more responsive to patients who are active participants in the medical encounter (Street, Gordon, & Haidet, 2007), but patients are more active when physicians are more facilitative. Perceived similarities between patient and physician can enhance this dynamic relationship (Street, O'Malley, Cooper, & Haidet, 2008). However, patients within any cultural group will have wide individual variability, and some will hold socio-cultural health beliefs that do not match a physician's perspective. Providing equitable care to these patients (a focus of culturally competent care) requires that a CC physician be able to adapt to different patients, individualizing their communication to accommodate the unique needs and characteristics of these patients. Many CC programs teach the importance of identifying patient preferences and negotiating diagnostic explanations and treatment options (Rapp, 2006; Thom, Tirado, Woon, & McBride, 2006). However, most do not provide sufficient instruction on how to tailor one's approach to the diverse needs of individual patients of particular cultural groups (Park et al., 2005).

However, a physician's ability to adapt to and manage the interplay of both cultural and personal features of the patient's beliefs and behavior is arguably enhanced when physicians are more reflective practitioners. Reflective practice differs from simple reflection in that it occurs "in action", that is, during the encounter, as opposed to after the encounter (Schon, 1983). Reflective practice, similar to

"thinking on your feet," requires situational awareness to recognize patient or interactive cues that adaptation might be needed and then combines that awareness with action. In essence, practitioners form hypotheses about what is occurring medically with a patient, assess the accuracy of their hypotheses through dialogue with the patient, and reframe their understanding through alternative hypotheses as more information is provided. However, a culturally competent physician must be able to apply reflective practice to more than "procedural" (or medical) aspects of their clinical reasoning. They should also use it to address "interactive reasoning" (i.e., how they engage with the patient and show respect for and incorporate the patient's values, commitments and beliefs) and "conditional reasoning" (i.e., understanding the impact of an illness on the patient) (Mattingly & Fleming, 1994). Physician adaptation has invisible cognitive components which occur between communicative events, as the physician considers what to do or say. However, physician adaptation is reflected in actual communication efforts.

For example, a female physician not engaged in reflective practice might interpret a male patient's silence as agreement with recommended treatment and intent to comply. However, a physician engaged in culturally competent reflective practice would notice the patient's body language as a cue signaling discomfort. She would draw upon an understanding of beliefs about physician authority and communication styles and form an alternate hypothesis – that the patient disagrees with the treatment plan but cultural norms prevent him from saying so because disagreement with those in authority is rude. That physician would ask the patient about his thoughts on the treatment. The patient might then disclose that he is uncomfortable with making decisions now because his wife and adult son are not with him (i.e., family-based decision-making). Thus, the physician's first hypothesis is wrong, but by engaging in reflective practice and pursuing reasons underlying the patient's discomfort, she was able to discover a reason, both cultural and patient-specific, that was complicating development and follow-through on a treatment plan.

In short, a reflective practitioner is able to form and assess these kinds of alternative hypotheses with ease, and shows a facility for adapting his/her next steps. A culturally competent physician must be able to assess both medical and socio-cultural aspects of the patient's situation and rearticulate his or her understanding to that patient until some consensus in understanding and goals is achieved.

Knowledge about core cultural issues

Most CC programs require physicians to demonstrate knowledge about culture and health, such as identification of cultural groups or social determinants of health (Kripalani et al., 2006; Lie et al., 2006; Rapp, 2006). Unfortunately, focusing on characteristics of cultural groups can inadvertently promote physician reliance on stereotypes (e.g., based on race or ethnicity, gender, socio-economic status) as the basis for their "culturally appropriate" interactions with diverse patients (Betancourt, 2003; Kripalani et al., 2006). The knowledge portion of training should focus

instead on increasing physician understanding of stereotyping as psychologically normal but important to counteract through various strategies (Burgess, van Ryn, Dovidio, & Saha, 2007). For example, rather than focusing on the group to which patients belong, CC programs should teach physicians to assess core cultural issues for each individual patient, that is, “situations, interactions, and behaviors that have potential for cross-cultural misunderstanding” (Carrillo et al., 1999, p. 830). This would both alert physicians to areas of potential cultural difference with any patient (not just those who appear to belong to different demographic groups) and help promote individualization as a strategy to reduce group-based stereotyping (Burgess et al., 2007). Core cultural issues which physicians should be taught to recognize and assess include beliefs about gender roles, physician authority, physical space, family roles, beliefs or practices about death, religious beliefs, and explanations of disease (Davidhizar, Giger, & Hannenpluf, 2006; Rapp, 2006). Communication is also a core cultural issue with several aspects, including recognition of status (e.g., use of first names), non-verbal behaviors (e.g., the meaning and use of gestures), and communication styles (e.g., what is considered rude or overly direct speech). In the earlier example, the physician used her knowledge of core cultural issues (beliefs about physician authority, communication styles) to form hypotheses about her patient’s communicative behavior and discover another core issue (family-based decision-making) that affected the patient’s ability to immediately make treatment decisions.

The culturally competent physician who knows nothing about the patient’s culture might still provide excellent care by employing three previously mentioned elements – communication repertoire, self- and situational awareness, and adaptability. However, we specifically include knowledge as a critical element of CCC, primarily to draw attention to the importance of focusing physician education about culture on the individual manifestation of core cultural issues rather than cultural group characteristics related to race, ethnicity, or any other single demographic marker.

The culturally competent communication model: integrating critical elements of cultural competence with communication skills

Many theoretical models of cultural competence (Bennett, 1986; Borkan & Neher, 1991) emphasize the developmental nature of achieving intercultural sensitivity, in which one moves through increasingly less ethnocentric phases (e.g., fear or minimization of different cultures) to become increasingly more ethnorelative (e.g., acceptance and integration of different cultures). Similarly, the Culturally Competent Communication Model (CCC Model, shown in Fig. 1) characterizes culturally competent communication as something that a physician achieves incrementally as a physician faces patients from different backgrounds. Physician efforts to gain a more advanced communication repertoire, develop greater self- and situational awareness, learn adaptation skills, and more readily recognize core cultural issues result in increased cultural competency. However, the CCC Model also emphasizes five

communication skill sets – non-verbal skill, verbal skill, recognition of potential cultural differences, incorporation of and adaptation to cultural knowledge, and negotiation/collaboration – in which each of these four critical elements can and should be optimized. At the most advanced levels of the model, physicians can use all the skills and employ all elements to engage in increasingly sophisticated, contextually appropriate communication behaviors with culturally different patients in complex interactions.

In the CCC Model, each of the four critical elements is equally important to achieving optimal communication skills. For example, adaptation may seem essential to the skill of incorporating cultural information obtained from the patient into subsequent encounters but less critical to non-verbal behavior. However, non-verbal behavior requires an awareness of others’ cues and an ability to modulate facial expressions and body language even when it is counter to a physician’s typical expression or posture. However, the model does not presume that physicians will develop proficiencies in each of the elements at the same pace, nor will each element be employed equally within each communication skill. In a single medical encounter, for example, a physician might display an advanced communication repertoire of general non-verbal and verbal behaviors, but have fewer and more basic options available for recognizing and assessing potential cultural differences. The same physician could have demonstrated great situational awareness of communication misunderstandings when speaking with a patient in a common language, but demonstrate significantly less awareness of those misunderstandings when required to use an interpreter. Further, the cultural content of some encounters can be more challenging than the content of others, and physicians may display different degrees of each element or skill, and thus CCC, in encounters with different patients.

Rather than a discrete skill, then, culturally competent communication is portrayed as an integrated set of specific communication skills that reflect one’s development along a continuum of cultural competence. Currently, there is no prototypical profile of how or to what degree the four elements must be employed for each skill to be fully optimized; this is an empirical question to be tested in future work. However, the CCC Model (See Table 1) does offer sample communication behaviors for each skill that reflect variations in knowledge about core cultural issues, communication repertoire, self- and situational awareness, and adaptability. The organization of these behaviors into each skill utilized the authors’ familiarity with diverse patients and physician–patient interactions to integrate, adapt, and expand existing CC and patient-centered communication literature. The Model designates how each skill might be manifested when applied to three unique functions of the medical encounter (i.e., building relationship, information assessment, and managing patient problems) (Cole & Bird, 2000; Lazare et al., 1995). Each skill in the model is described below, with sample behaviors shown in Table 1. The skills are not presented in order of difficulty or importance per se; rather, each is equally important with potentially different levels of difficulty depending on the characteristics of the medical encounter (e.g., patient, presenting problem, prognosis, etc.)

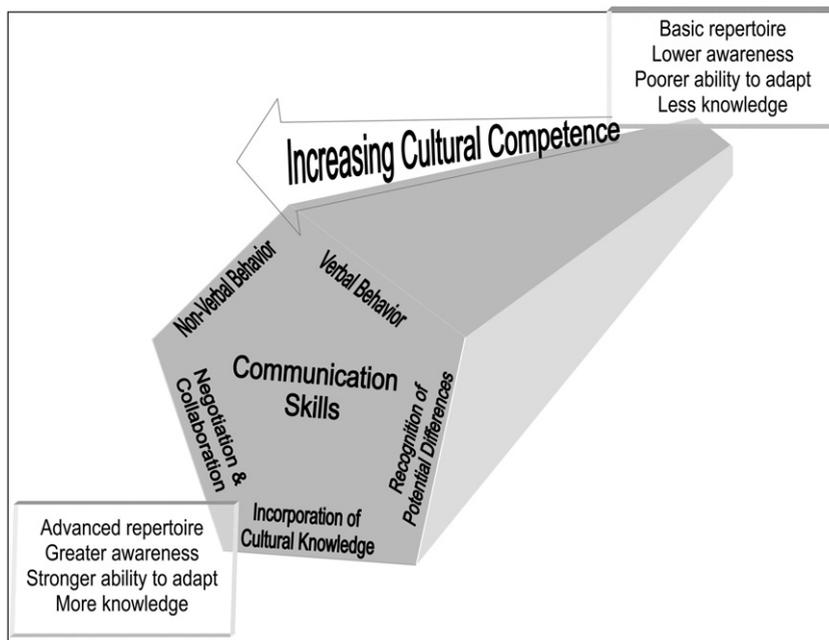


Fig. 1.

Non-verbal skill

A skilled physician can use many non-verbal behaviors to reflect the physician's respect, concern and interest in the patient's well-being (Coulehan et al., 2001; Epstein, 2006). Behaviors associated with this skill are positively received by people of most cultural groups and are displayed naturally when one has a positive orientation to the patient. These "potentially least offensive" non-verbal actions (in Table 1) include listening actively (Berlin & Fowkes, 1983) and focusing on the patient, and moderating culturally variable aspects of the interaction such as eye contact, touch, physical space, facial expressiveness, and the use of gestures (Davidhizar et al., 2006; Juckett, 2005; Misra-Hebert, 2003).

Verbal behavior skills

Like non-verbal behaviors, the use of verbal behavior should indicate respect and empathy for the patient, both as a patient and as an individual (Epstein, 2006). The behaviors associated with this skill (see Table 1) provide a means of asking about the patient's problems, as well as showing understanding of his or her circumstances, which help form a connection with the patient. Utilizing information from a previous visit to ask about their particular clinical symptoms, their family or work lives, etc., for example, suggests that the physician cares and sees the patient as an individual. Physicians with these basic verbal skills invite the patient's perspective of their symptoms or illness and compose non-judgmental reactions, reflections, and follow-up questions. Physicians should also be able to identify emotional cues from the patient and utilize the verbal skills in their communication repertoire to acknowledge, reflect, and calibrate that emotion (Coulehan et al., 2001; Stewart, Brown, Weston, McWhinney, &

McWilliam, 1995). Such behaviors as indicating non-judgmental concern and interest may be more critical for building relationships, while reflecting and checking for understanding may be more important to assessment or problem management.

These patient-centered verbal and non-verbal behaviors are "safe" because most patients of any cultural background are likely to be responsive and to view them favorably (Coulehan et al., 2001; Epstein, 2006; Felgen, 2003; Giger & Davidhizar, 2002). (If patients vary in their response, physicians may use other skills described later to aid in communicating.) These behaviors have a high probability of conveying basic human respect to the most diverse patient population and are considered by many patients fundamental to being culturally competent (Mull, 1993; Shapiro et al., 2002). Using these behaviors implicitly requires that a physician set aside, at least temporarily, categorical stereotypes based on demographic factors and engage the person as an individual. The intersection of patient-centeredness and cultural competence is most clearly evident in these behaviors, where patient-centered communication is a critical foundation for culturally competent communication skill development. Even if a physician's cultural knowledge, situational awareness, and adaptability skills are limited, these patient-centered communication behaviors associated with non-verbal and verbal skills indicate a modest degree of CC and are likely appropriate for most patients regardless of cultural background. They are applicable to any of the functions of the medical encounter.

Recognition and exploration of potential cultural differences

During an intercultural communication encounter, it is not uncommon for the participants to show confusion or

Table 1

Sample behaviors for each skill in the culturally competent communication model.

Culturally competent communication skills	Application to each function of clinical encounter	Useful sample behaviors
Non-verbal behavior skills	<i>Applicable to all functions</i>	<ul style="list-style-type: none"> ■ Be on time; Don't rush the patient. ■ Be attentive; Be an active listener - Allow silence; do not interrupt; - Use body positioning to indicate interest - Do not read the chart or write notes while patient is talking - Limit touching; respecting preferences for physical space; providing explanation for intruding into personal space - Make eye contact but do not stare or force prolonged eye contact ■ Limit gestures ■ Mirror patient's facial expression to indicate empathy; ■ React with non-judgmental expressions ■ Make facilitative responses (nodding, minimal verbal expressions)
Relevant references for non-verbal skill		(Barrier, Li, & Jensen, 2003; Coulehan et al., 2001; Epstein, 2006; Shapiro et al., 2002)
Verbal behavior skills	<i>Establishing relationship</i>	<ul style="list-style-type: none"> ■ Utilize title and last name unless invited to do otherwise ■ Indicate concern/interest for <u>patient as an individual</u>; - "Tell me about yourself." - "How's your work at XXX going?" ■ Indicate concern/interest for <u>individual as patient</u>; - "How have you been feeling?" ■ Use non-judgmental verbalizations; (not "why?" but "how," "what," etc.) ■ Ask for and reflect observed patient emotion ("How are you feeling about your symptoms?" "You seem sad [tired, frustrated, unsure].")
	<i>Gathering information</i>	<ul style="list-style-type: none"> ■ "What brings you in today?" ■ Reflect what the patient shares (e.g., "Sounds like you think...") ■ Summarize; Request feedback ("Did I get that right?") ■ "What else do you want to talk about?"
	<i>Managing the problem</i>	<ul style="list-style-type: none"> ■ Invite questions about your perception of diagnosis and treatment - "Do you understand or have questions?" - "Stop me if you're not sure what I'm saying."
Relevant references for verbal skills		(Berlin & Fowkes, 1983; Carrillo et al., 1999; Eanet & Rauch, 2000; Kagawa-Singer & Kassim-Lakha, 2003; Kleinman, 1988; Thom et al., 2006)
Recognition of potential cultural differences	<i>Establishing relationship</i>	<ul style="list-style-type: none"> ■ Attend to patient discomfort ■ Recognize negatively-perceived behavior and assess cause ■ Acknowledge others accompanying patient
	<i>Gathering information</i>	<ul style="list-style-type: none"> ■ Explore changes in the patient's life, especially for immigrants ("How is medical care different here than in your country?") ■ Assess the patient's explanatory model for the disease and treatment ■ Ask about tangible and community resources ■ Learn about core issues for the patient's cultural group (e.g., "Does anyone else need to be involved in your decisions?") ■ Assess factors that contribute to understanding (education, knowledge about disease) ("Are you familiar with X?") ■ Assess social context that can influence ability to care for self (e.g., SES, physical living environment), social stressors, literacy and languages ■ Elicit patient preferences for information and decision-making. "Are you the type of person who - wants to know everything, good and bad?" - prefers to make your own decisions, or do you feel more comfortable following my recommendations?"
	<i>Managing the problem</i>	<ul style="list-style-type: none"> ■ Ask for the patient's perception of recommended treatment. ■ Reflect the patient's perspective; Request feedback ■ Acknowledge differences in your perception and the patient's perception of problem or treatment. ■ Invite questions "Do you understand?" "Do you have questions?" ■ Attend to body language and facial expression, silence, and other cues that a patient disagrees or is uncomfortable with diagnosis or treatment
Relevant references for recognizing cultural differences		(Berlin & Fowkes, 1983; Carrillo et al., 1999; Coulehan et al., 2001; Eanet & Rauch, 2000; Kagawa-Singer & Kassim-Lakha, 2003; Kleinman, 1988; Lee et al., 2002; Lipkin, Quill, & Napodano, 1984; Makoul & Clayman, 2006)

710	Incorporation of cultural knowledge	<i>Establishing relationship</i>	<ul style="list-style-type: none"> ■ Utilize previously learned knowledge to: <ul style="list-style-type: none"> – guide appropriate non-verbal behavior – determine familiarity (e.g., title/last name vs. first name, greeting style) – include others who are present; and according to earlier assessment of their role – determine probing questions about medical and socio-cultural context ■ Adapt behaviors that created unease to increase patient comfort ■ Adapt provision of information to patient's preference ■ Include patient in decision-making to the degree he/she prefers 	771
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719		<i>Gathering information</i>	<ul style="list-style-type: none"> ■ Assess degree of difference in patient explanatory model and physician's biomedical model ■ If necessary, assess patient's flexibility to broaden explanatory model to include biomedical aspects 	780
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723		<i>Managing the problem</i>	<ul style="list-style-type: none"> ■ Determine aspects of treatment that you can be more flexible about ■ Discuss diagnosis or treatment options in ways that are consistent with the persons' education, medical knowledge or experience, and explanatory model ■ Acknowledge implications of differences in patient's explanatory model and a biomedical perspective ■ As possible, incorporate socio-cultural aspects into biomedical explanations of illness and its treatment ■ Creatively develop options/plans for treatment that reflect the patient's preferences and needs. ■ Provide written information that is language/literacy appropriate ■ Monitor patient's understanding of and affective response to information, and reconcile potential misunderstandings. 	784
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733	Relevant references for adapting			794
734	<i>to cultural knowledge</i>		(Berlin & Fowkes, 1983; Misra-Hebert, 2003; Reynolds et al., 2005)	795
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736	Negotiation & collaboration	<i>Establishing relationship</i>	NA	797
737		<i>Gathering information</i>	<ul style="list-style-type: none"> ■ Assess the patient's priorities for treatment ("What bothers you the most?") ■ Ask about patient's acceptance of the plan ("How do you feel about this plan?") ■ Assess self-efficacy for carrying out treatment <ul style="list-style-type: none"> – "Do you think you can follow the plan?" – "What would help you?" ■ Assess patients' concerns, expectations <ul style="list-style-type: none"> – "What worries you most about this diagnosis/treatment?" – "How much do you consider risks and long-term complications in your decisions? Or do you want to do whatever it takes?" ■ Assess reluctance to make a choice and reconcile. <ul style="list-style-type: none"> – "You seem reluctant to commit one way or another. Please tell me your concerns." ■ Include patient and family in determination of what information is sought and provided ("What other information is important for me to know that we haven't talked about?") ■ Consider preferences; ■ Describe your treatment priorities and justifications ■ Describe tests, procedures, treatments in ways that are consistent with the persons' education, medical knowledge or experience, literacy, and explanatory model ■ Offer options and indicate a choice needs to be made; Work with patient for shared decisions; affirm choices <ul style="list-style-type: none"> – "So are you leaning toward X treatment or Y?" – "So you want to take medicine X, but not Y? If we can find you a discounted rate, would you consider doing that next month?" ■ Work with other family members ■ Demonstrate a willingness to work with alternative healers or treatments ■ Supply information about community resources 	798
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750		<i>Managing the problem</i>	<ul style="list-style-type: none"> ■ Consider preferences; ■ Describe your treatment priorities and justifications ■ Describe tests, procedures, treatments in ways that are consistent with the persons' education, medical knowledge or experience, literacy, and explanatory model ■ Offer options and indicate a choice needs to be made; Work with patient for shared decisions; affirm choices <ul style="list-style-type: none"> – "So are you leaning toward X treatment or Y?" – "So you want to take medicine X, but not Y? If we can find you a discounted rate, would you consider doing that next month?" ■ Work with other family members ■ Demonstrate a willingness to work with alternative healers or treatments ■ Supply information about community resources 	811
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762	Relevant references for		(Berlin & Fowkes, 1983; Carrillo et al., 1999; Lee et al., 2002; Levin et al., 1998; Makoul & Clayman, 2006)	823
763	<i>negotiating and collaborating</i>			824
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create social distance based on possible misunderstanding related to a discrepancy between the intent of a message and the way it was perceived. The physician who observes such patient reactions and who considers that a cultural boundary may have been crossed is demonstrating skill at recognizing potential cultural differences. Knowledge of core cultural issues and situational awareness permits a physician with this skill to monitor potential "cultural misunderstandings;" that is, when different interpretations of the same behavior interrupt the development of the patient-provider relationship or hinder assessment and treatment (Kim-Godwin et al., 2001; Rauch, 1999). The CCC Model (see Table 1) incorporates basic behaviors of a communication repertoire for relationship building. For assessment, Kleinman's questions for assessing a patient's explanatory model of the symptoms and/or illness are integrated into the model (Kleinman, 1988; Kleinman, Eisenberg, & Good, 1978), as well as communication recommendations for other areas of inquiry including: the patient's community and family; skills and abilities that aid the patient and his/her family in dealing with the illness; factors that contribute to understanding health issues (e.g., education, mental acuity, familiarity with disease); aspects of the patient's environment that influence his/her ability to care for him/herself (e.g., socio-economic factors, structural environment, stressors); and emotional implications of illness (Carrillo et al., 1999; Eanet & Rauch, 2000; Kagawa-Singer & Kassim-Lakha, 2003; Stuart & Lieberman, 1993). With respect to managing the encounter, the physician skilled in recognizing potential cultural differences shares his/her perception of the problem and its treatment, invites patient questions, allows for potential differences between his/her perspective and the patient's, and explores the patient's preferences for involvement in medical decision-making. This requires openness, if not adaptability, on the physician's part to seek out, and accept, an alternative perspective.

Incorporation of and adaptation to cultural knowledge

Some physicians may be able to recognize real or potential socio-cultural problems in the encounter, but find it difficult to adapt because of limited cultural knowledge, communication skills, or difficulty integrating socio-cultural perspectives of illness with biomedical perspectives. The physician skilled at integrating a patient's cultural values or beliefs into the encounter, however, has the awareness and ability to adapt communication behaviors to maximize the patient's comfort, reconcile misunderstandings, and be responsive to the patient's values. As shown in Table 1, previously learned information (i.e., from this or similar patients) guides this physician's familiarity with the patient as well as selection of follow-up questions of both a biomedical and socio-cultural nature. For example, physicians may want to assess how much the patient's explanatory model of the symptoms or illness differs from his or her own, and how much flexibility the patient has for broadening his/her model. Physicians with this skill discuss diagnostic options in ways consistent with the patient's education, medical knowledge or experience, and explanatory model of the illness or symptoms. They

incorporate socio-cultural aspects into their biomedical perspective of the illness and demonstrate a creative facility for offering individualized treatment options that are medically sound and reflective of the patient's values, skills, resources, and understanding (Lipkin, Quill, & Napodano, 1984). While the specific nature of these questions or discussion points depends a great deal on the cultural factors affecting the encounter, a physician who does not adapt to information provided by patients is likely to leave socio-cultural misunderstandings unreconciled and project an attitude of disregard for the patient and his/her individual situation.

Negotiation & collaboration

This skill during the medical encounter requires the physician to operate with the utmost awareness and adaptability to negotiate a shared understanding with the patient and to reach agreement on how the patient's symptoms will be prioritized, diagnosed, and treated (Carrillo et al., 1999; Lipkin et al., 1984; Makoul & Clayman, 2006). This is especially important when physicians and patients are at odds over the best course of action because of culture-related differences in their viewpoints. The successful mastery of previous skills should provide basis for a relationship upon which to undertake this enterprise (Lee, Back, Block, & Stewart, 2002). Assessment behaviors, as shown in Table 1, include soliciting patient preferences and priorities for treatment, evaluating the patient's self-efficacy for carrying out a proposed plan or how it might need to be modified to address potential barriers, and assessing sources of reluctance to make choices. Problem management behaviors include demonstrating a willingness to work with alternative healers or treatments, negotiating a shared understanding of the illness, being sure the patient knows that there are choices to make, discussing the risks and benefits of different treatment options in ways that are individualized to the patient's socio-cultural and biomedical context, and negotiating the timeline upon which choices can be made. Previous research suggests that physicians in race-discordant patient relationships may be less participatory in decision-making (Cooper et al., 2003). A physician who is not able to communicate with a patient as a partner in his or her health management may unintentionally be responding to stereotypical assumptions about patient capabilities or resources.

Many advocates of patient-centeredness and cultural competence, including the authors, are supportive of shared decision-making models of patient-physician interactions. However, some patients prefer a more doctor-centered approach, in which the physician is more directive and the patient more passive in the encounter. As previous studies demonstrate (Krupat et al., 2000), patients who prefer a doctor-centered approach tend to do well with either doctor-centered physicians or patient-centered physicians, because patient-centered physicians will adapt their style to meet the assessed preferences of the patient. Ultimately, a physician with high levels of CCC demonstrates adaptability such that the physician identifies patients' preferences for shared decision-making and

incorporates those preferences into the care provided, even if the physician prefers an alternate model.

Strengths and limitations of the CCC model

We believe the CCC Model has a number of strengths. First, it allows the clinical encounter to include differing levels of cultural complexity. Cultural beliefs may not be central to a case (Kleinman & Benson, 2006). In some situations, however, cultural factors may be critical, such as in end of life situations where culture can influence if and how death is talked about, and with whom, when decision-making regarding end of life care (Della Santina & Bernstein, 2004; Giger, Davidhizar, & Fordham, 2006; Kagawa-Singer & Blackhall, 2001). If a physician makes assumptions about the patient based on categorical stereotypes or ignores cultural issues altogether, he/she actually hinders the interaction and may negatively impact care and outcomes. The CCC Model accommodates cultural complexity, in part because of its emphasis on personalized assessment and care. The model also acknowledges that as physicians encounter patients from different cultures and clinical situations become more complex, physicians may encounter more risk for specific cultural misunderstandings. However, the model focuses on the physician's use of self-, other-, and interaction-awareness to inform subsequent interactions, which improves the likelihood of reconciling any misunderstanding.

Second, this model has both heuristic and practical significance. Because it relies on identifiable behaviors of CCC, it lends itself to measurement. This emphasis on skills and behaviors offers pragmatic tools for identifying target outcomes of physician training and is consistent with several recent models of teaching and assessing general communication skills (Duffy et al., 2004; Krupat et al., 2006; Lang, McCord, Harvill, & Anderson, 2004; Roter & Larson, 2002; Schirmer et al., 2005). Although it focuses on the physician, the model emphasizes that the interplay between physicians and patients in a single medical encounter is integral to subsequent physician behavior in that same encounter, as well as future ones (Epstein, 2006; Roter, 2002; Suchman, 2006).

The CCC Model assumes that physicians are willing to adopt a patient-centered approach and value CC. This may not be the case, with some physicians preferring a more doctor-centered model of care, or the biomedical model of care in which the approach is disease-oriented (Marvel, Major, Jones, & Pfaffly, 2000). Further, Vega (2005) has argued that many clinicians view CC as information that is not essential to clinical competencies. We believe that to be culturally competent, a physician must embrace patient-centered care, regardless of his or her preference for how care is delivered (Duggan, Geller, Cooper, & Beach, 2006). Some might regard the CCC Model as a special case of patient-centered communication with the focus on how patient-centered care might manifest itself when cultural differences exist between physician and patient. As noted earlier, many aspects of our model overlap with patient-centered care. However, the CCC Model adds to the current literature by integrating CC with patient-centered communication, and identifying specific communication

issues that relate to ways in which culture may be manifest in clinical encounters.

We are also aware of the model's limitations and the need for research assessing the model's utility. First, the model does not currently suggest how or to what degree the four elements must be employed within each skill for culturally competent communication. This is an empirical question to be tested in future work. Second, the ability to employ these skills is significantly challenged when patients and physicians do not speak the same language. The CCC Model does not specifically address this added layer of complexity. Several excellent behavioral guidelines have been offered for choosing and working with translators, including those of Flores (2000) and Levin (Levin, Like, & Gottlieb, 1998; Like, 2000). However, being able to deliver culturally competent care through an interpreter is complicated. Though it is clear that a physician must have the highest levels of each essential element – an advanced communication repertoire, considerable awareness and adaptability, and some knowledge of core cultural issues – it is the work of future research to examine how these critical elements are manifest in each skill when language discordance is a factor.

Conclusion

On the surface, the emphasis on skills and competencies might suggest a reductive approach to understanding and working with individuals from different cultures. However, our underpinning philosophy is more in keeping with an ethnographic approach, that is, the CCC Model “emphasizes engagement with others and with the practices that people undertake in their local worlds” (Kleinman & Benson, 2006, p. 1674). Thus the model simply identifies practical ways through which an empathetic, mindful, and reflective physician can engage with members of diverse populations.

The CCC Model emphasizes the incremental development of communication skills for managing the cross-cultural nature of the clinical encounter. The CCC Model optimizes a physician's communication repertoire, self- and situational awareness, adaptability and cultural knowledge within each skill component. This allows the physician to apply contextually appropriate communication behaviors to engage with culturally different patients in complex interactions. By clarifying the definition and manifestation of these behaviors in practice, the model offers a step toward “unpacking” CC (Vega, 2005), and toward evaluating its impact on care.

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