

Caring Across Cultures: An Exploration of Culturally Competent Health Care for Latino Families in a Pediatric In-Patient Unit

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Caring Across Cultures: An Exploration of Culturally Competent Health
Care for Latino Families in a Pediatric In-Patient Unit

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This thesis is dedicated to the staff and patients at the Nueva Vida Clinic in Ciudad Sandino, Nicaragua who inspired me to view health in an entirely new way and to work for improved health care for all people.

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Abstract

In an age in which diversity and healthcare inequalities are prominent issues, culturally competent care has emerged as a popular response. However, there seems to be a gap between this academic interest and the attempts to implement cultural competency in the American healthcare system. The aim of this qualitative research was to explore the link between culture and health and to uncover what cultural competency might mean on a practical level through a case study of the pediatric in-patient units of an urban hospital in Boston, Massachusetts. Through participant observation over the span of two months, as well as 20 semi-structured interviews with 14 healthcare providers and 6 bilingual Latino parents of pediatric patients, I investigated the challenges that these groups face in providing and seeking care, respectively. The results of this project attempt to give voice to the families and their providers, as well as suggest how the hospital can better accommodate the needs of the Latino population. Overall, this project has revealed the complexity of the links between culture and health, and indicated that there is no single model of cultural competence that can adequately capture this complexity. Ultimately, relationships and good communication are at the core of the cross-cultural medical encounter, and may serve to create a more culturally welcoming atmosphere for patients of all backgrounds.

Key words: Culture; health; pediatrics; providers; cultural competence; Latinos

Chapter I

Preface

The important thing is not to stop questioning. Curiosity has its own reason for existing. One cannot help but be in awe when he contemplates the mysteries of eternity, of life, of the marvelous structure of reality.

-Edmund Burke

Culture is a filter that colors our every experience, helps us to assign meaning to our interactions, and influences our behaviors and approaches to everything from dietary choices to end-of-life decisions. While culture is most recognizable in traditions associated with a particular ethnic group, nationality, or religion, it is often a more ubiquitous and subtle element of our daily lives, whether or not we are aware of its importance. In fact, many individuals struggle to pinpoint the influences of culture on their own lives or to describe their culture at all. This is so because culture is integral to one's sense of self and so normal that it may not seem different from the experience of anyone else. One's own cultural practices and values are not necessarily noteworthy because they are woven into the fabric of one's everyday experiences. While a variety of definitions of culture exist, it can broadly be understood as, "the full spectrum of values, behaviors, customs, language, race, ethnicity, gender, sexual orientation, religious beliefs, socioeconomic status, and other distinct attributes of population groups" (American 2004:1677). Since culture is so significant to the ways in which individuals live their lives and understand the world, it is important that the institutions that were designed to serve these individuals, such as healthcare, take culture into account.

The culturally competent model of healthcare was developed as a means for overcoming ethnocentrism within medicine and for increasing the responsiveness of the

healthcare system to the needs of an increasingly diverse nation. In an age in which diversity is such a hot button issue, especially within healthcare, culturally competent care has become a fashionable topic of research that has garnered much attention within medical sociology, anthropology, psychology, and the medical sciences. However, there seems to be a disconnect between this academic interest and the practical attempts to make cultural competency a core component of the American healthcare system. For many, it remains a positive but vague idea, relegated to continuing medical education workshops or lectures in the medical school curriculum. It is necessary that the academic and medical communities work together to rescue the concept of cultural competency from being labeled as an overly idealistic idea in a time when it is needed more than ever. It is a communal responsibility to engage with this model of care, explore its ability to transform the experiences of marginalized populations, and identify its limitations.

Through this research project, I attempted to understand the link between culture and health and to uncover what cultural competency might mean on a practical level through a case study of an urban hospital in Boston, Massachusetts (referred to hereafter as “Boston Hospital”). I sought to address the general question: what is the American medical system doing to accommodate the cultural and linguistic needs of their diverse patient populations in providing quality health care? To narrow the broad scope of this question, I focused more specifically on a three secondary questions: What is the pediatric inpatient unit of Boston Hospital doing to address issues of cultural competency for the subpopulation of Latino families? What challenges do these families currently face and what changes might be made to overcome them? What challenges do health care providers experience in caring for these families?

This inductive, qualitative research project was not hypothesis driven, but instead explored the efforts of one small corner of the greater healthcare system through the accounts of Latino patients and their health care providers. My primary aim in this project was to give voice to both of these groups and to tell their stories, which often go untold. In telling these stories side by side, I hoped to paint a picture of the state of cultural competency at Boston Hospital, and to help the medical team to better understand the experiences of the Latino families they serve. The inpatient units of hospitals like Boston Hospital are often chaotic environments where there is little time for medical providers, interpreters, and families to communicate about anything beyond the immediate needs of the sick child. I see my role as a liaison of sorts, objectively observing and retelling these interrelated experiences in a single space. It is my hope that the common themes that arise from the data produced by this research will lead to some conclusions regarding the challenges and obstacles that must be overcome in the implementation of culturally competent healthcare.

My own interest in cultural competency springs from my experience researching and volunteering in the Nueva Vida Clinic in Ciudad Sandino, Nicaragua during the summer of 2010. The project was funded by a grant from the Boston College Fellowship Committee and allowed me to conduct informal sociological research on the intersections between poverty, health, and hope within the lives of the patients who rely upon the clinic for their care. In doing so, I learned more than I have ever learned in an academic classroom and came to understand health and healthcare in ways that stretched my own preconceived notions. As a pre-medical student, I had never before considered health beyond the Western, American model of medicine, as I didn't realize that the individual

experiences of health and illness extend beyond a universal biomedical model. This experience made me question how Latino immigrants or children of Latino immigrants might navigate the American healthcare system. I wondered how complex views of health and health care, embedded in culture, might be lost or misunderstood in medical assessments and how these events could be avoided.

As with most research, I will leave this project with even more questions than I began with. I have not definitively illuminated the complex links between culture and health, nor have I proposed a model for cultural competency designed for Latino families. Instead, I have asked questions that I hope will inspire further research and invite changes on an individual, departmental, and institutional levels at Boston Hospital. Models may never fully solve the current problems, and clear-cut answers may not exist, although the questions themselves must be asked again and again until progress is made toward a better and more compassionate healthcare system.

Chapter II

Literature Review

Health is the place where all the social forces converge.

Reed Tuckson, M.D.,

Vice President, American Medical Association

Physical and mental health are essential preconditions for the basic human flourishing of individuals, families, and societies. Despite the widespread acceptance of this claim, healthcare systems have been historically criticized for their inability to meet the needs of the societies they serve. The failure to meet the health needs of a society as a whole is most obvious when one considers the low standard of care offered to society's weakest members, including refugees, the homeless, those suffering from mental illness, the uninsured, and recent immigrants. This failure has widespread consequences. As Cardinal Roger Mahony once wrote, "Any society, any nation, is judged on the basis of how it treats its weakest members - the last, the least, the littlest" (1998). In recent years, the healthcare disparities that exist between those with power, whether economic, social, or cultural in nature, and those living on the margins of society have received greater attention from the U.S. medical community. The Institute of Medicine report *Crossing the Quality Chasm: A New Health System For the 21st Century* notes that, "[h]ealth care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap but a chasm" (U.S. Committee 2001:1). This chasm threatens to widen unless significant changes are made with the needs of vulnerable populations in mind. These changes must be made in different spheres and on different scales. Macro-scale changes should include national health care legislation to increase access and affordability of care

(as begun by the recent healthcare reforms), bolster medical education, and support awareness campaigns to combat stereotypes. Micro-scale changes should influence the approaches to care within medical institutions and the ways in which healthcare providers are trained.

Health Disparities

A strong foundation of research supports the conclusion that persons of color receive unequal health care and are at risk of poor health outcomes in comparison to white Americans (Mead 2008:19, Health Policy 2004:2-3). The Institute of Medicine (IOM) Report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* defines health disparities as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (Smedley et al. 2003:32). Disparities are based on the operation of the healthcare system and the overall legal and regulatory climate, as well as discrimination at the clinical and societal levels. This seminal work publicized the disparities between the morbidity and mortality rates of racial and ethnic minorities and those of non-minority white Americans. It argued, as well, that such disparities reflect complex individual, social and environmental factors (2003). The report’s conclusion is especially disconcerting: minority patients receive a lower quality of care even when compared to non-minorities with an equivalent level of access. In addition to the crippling “threshold” barriers that limit minorities’ access to care, such as lower socioeconomic status, lower rates of health insurance, higher use of Medicaid, higher co-payments, geographic scarcity of providers and facilities, and inadequate transportation,

the report argues for consideration of other invisible factors that may also contribute to these disparities. Such factors include biases and discrimination (2003:34).

Unequal Treatment assesses the extent of disparities in the quality of care provided to racial and ethnic minorities, evaluates potential sources of these disparities, and makes recommendations for medical education and systemic intervention strategies (2003). It is important to note the limitations of such a pursuit, as both health and health disparities are an amalgamation of numerous tangible and intangible factors, including socioeconomic position, individual risk factors, sociocultural factors, environmental health risks, and behaviors, among others. The report notes that “Healthcare is therefore necessary but insufficient in and of itself to redress racial and ethnic disparities in health status” and that such problems can only be addressed through a systemic strategy to address socioeconomic inequality (2003:35). How, then, can this web of factors be untangled in order to provide for its weakest members and, as a result, for the health of our nation as a whole? What must be done on the level of health systems, in major urban teaching hospitals, rural health centers, and in clinics during the doctor-patient interaction? How can a sociological lens be applied to these challenges and potential interventions to examine the importance of culture and power in the medical encounter? This project will begin to address such questions.

Culture, Medicine, and the Culture of Medicine

The real tragedy of widespread inequality and health disparities lies in its impact on individuals and families. Behind statistics and reports there are real people whose quality of life and ability to flourish are compromised by the systemic failure to acknowledge and accommodate their unique health needs. In the popular book, *The Spirit*

Catches You and You Fall Down: A Hmong child, her American doctors, and the collision of two cultures, journalist Anne Fadiman uses a critical lens to explore a particularly tragic case in which one family's needs were neither understood nor met (1997). Fadiman raises many important questions throughout the book on how the healthcare system cares for the marginalized, noting,

The medical establishment appears to be waking up to the fact that since 1990, more than half the population growth in the United States has come from immigrants and their children- and that many of these immigrants, even if they can get to the hospital and pay for their treatment, may find mainstream health care culturally inaccessible (1997:270).

The notion of cultural inaccessibility that Fadiman raises is an important intangible contributor to the health care disparities as discussed in the *Unequal Treatment* Report. This excerpt raises other questions for consideration: what is the role of culture in health and healthcare? Furthermore, how can the clash between the “culture of biomedicine,” or the culture of the physician and the culture of the patient create a barrier to the quality of care? Finally, how can cultural differences be accommodated through policies and practices so that these barriers are diminished?

Due to its saliency, culture is just as present in provider-patient interactions in emergency rooms and clinics as in any other social interaction. Dr. Arthur Kleinman, a Harvard psychiatrist, anthropologist, and leader in cross-cultural health care argues that cultural factors are central to diagnosis, treatment and care (Kleinman and Benson, 2006). Kleinman claims that every physician-patient encounter is cross-cultural because of the difference between the “illness experience” as understood by the patient and the “disease process” as understood by the physician (Kreier 1999). This “primordial cultural divide” is only widened when additional cultural discordances based on race and ethnicities exist.

In fact, Kleinman writes, “the culture of biomedicine is now seen as key to the transmission of stigma, the incorporation and maintenance of racial bias in institutions, and the development of health disparities across minority groups” (2006:1673).

According to this line of thought, the medical culture must be critically examined for its impact on both institutions and individuals. The AAP echoes Kleinman’s theory of the cross-cultural medical encounter, applying it to pediatrics in a practical way:

Regardless of their background, all patients and their families have culturally based concepts about health, disease, and illness. At the same time, the cultural attributes of the pediatrician may differ from that of the patient or family or the pediatrician’s colleagues (2004:1679).

Recognizing the role of culture in health beliefs and decision-making, whether culture is tied to ethnicity or professional training, is foundational to providing quality care. While this theory seems simple, its operationalization is quite complex.

DeVecchio Good et al. fleshed out the concept of the “culture of medicine” through their consideration of two questions. First, “How do the culture of medicine, the training of medical students and residents, and the organization and delivery of healthcare affect patient treatment in such a way as to produce obvious and documented disparities in therapeutic action?” Second, “How could well-meaning people (healthcare providers) provide inequitable care to minority and non-minority patients?” (2003:595). In this work, DeVecchio Good et al. describe the “medical gaze” as the “knowledge frame” adopted by doctors and a central aspect of the culture of medicine (597). Within this culture, new doctors are trained to “see” what is relevant to the medical encounter, listen to a patient narrative for diagnostic criteria, speak the medical language, and act according to acceptable behaviors (599). The authors describe the “medical gaze and its underlying ideologies and political economy of what constitutes legitimate medical

knowledge, bioscience, and appropriate medical decision-making” (597). These references to ideologies and “legitimate knowledge” leads one to question whether the actions of providers, as informed by their medical training, inadvertently contribute to health disparities or whether these disparities are in fact a manifestation of deep-seated societal inequalities. These authors argue that disparities are the result of multiple interacting forces, which may be “structural, economic, environmental, political and attitudinal” (597-8). It would be dangerous to assume that this tentative concept of a biomedical culture is universal in training all providers to see patients through the lens of the medical gaze, or to blame this culture for the entrenchment of health inequalities. However, this concept can be used to reflect upon the accounts of providers and provider-patient interactions presented in later chapters.

The concept of cultural health capital builds upon the works of Kleinman and DelVecchio Good and adds an element of sociological theory relevant to my own research. Janet Shim developed the concept of cultural health capital (CHC), which she defines as, “the repertoire of cultural skills, verbal and nonverbal competences, attitudes and behaviors, and interactional cycles cultivated by patients and physicians alike, that, when deployed, may result in more optimal health care relationships” (2010:1). The concept of CHC that Shim develops and the theoretical framework surrounding it is based on Pierre Bourdieu’s theory of cultural capital. According to Bourdieu, cultural practices and resources serve as forms of capital that individuals can leverage to their advantage in their relationships with others. This concept can be used to understand how invisible elements of the patient-provider interaction (health capital) can lead to disparities in health care. According to Bourdieu, the interaction and use of these forms

of capital are entwined in hierarchies and power dynamics, contributing to inequalities (Shim 2010:2). In the case of CHC, forms of capital such as one's interactional style, one's ability to understand biomedical information, or one's linguistic abilities determines one's position in the hierarchy of the healthcare system. These forms of capital make a "toolkit" that patients may use in different situations (3). While some patients may have many tools in their "toolkit," others may lack even the basics. Those with many tools can use them to avoid disease or more deftly navigate the medical encounter to obtain better care and services, as compared to those who cannot access these same tools. It should also be noted that this use of CHC may not be calculated, but rather a part of the "habitus" that an individual possesses, a term Bourdieu uses to describe "general styles, habits, and dispositions that indelibly influence the direction, manner, and shape of their actions" (5). Whether or not one is aware of this power, each individual is afforded access to different forms of health capital based on his or her race, culture, education, etc. Because of this, each medical encounter is laden with unspoken value and invisible power dynamics. The CHC framework links such micro-interactional dynamics to the formation of macro-structural inequalities in the healthcare system (12).

Cultural Competence: A Background

Cultural competence is a relatively new and exploratory approach to health care that is based on the concept that culture is relevant to patient health and should be considered in the medical encounter. DelVecchio Good et al. describe the logic behind this new model of care:

The developing interest in cultural competence...is both a pragmatic response to the increasing proportion of ethnic minority individuals...and the failure of a strictly biomedical model in achieving uniform outcomes

in this diverse population and a moral response to the inequities of healthcare among ethnically diverse populations (2003:607).

As of yet, there is no single accepted definition for this developing response, nor is there a model for its implementation. Betancourt, et al. conducted a literature review in order to produce a practical definition and framework for interventions surrounding this idea.

Their definition is as follows:

‘Cultural competence’ in health care entails: understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations (2003:297).

This definition is instructive in its multi-level approach that recognizes the influence of culture on the personal, clinical, and societal levels. The scope of this definition also encourages a focus on interventions that could narrow the inequality gap. Betancourt et al. also recognize the web of factors influencing health that were mentioned in the IOM report:

The field of cultural competence has recognized the inherent challenges in attempting to disentangle ‘social’ factors... from ‘cultural’ factors vis-à-vis their influence on the individual patient. As a result, understanding and addressing the ‘social context’ has emerged as a critical component of cultural competence (2003:294).

This observation creates a space where sociological research can engage with the medical community to bolster efforts toward cultural competence. Sociological insights into these social and cultural factors can help to connect the culture of medical providers with the culture of particular patient populations.

While cultural competence is the most commonly used term for this concept, and the one that will be used for my own particular research, there are numerous other

reformulations of competence to consider. The AAP chooses to use the phrase “culturally effective pediatric care” as it is more inclusive and is focused on the outcomes of the interaction (2004). Holland and Courtney provide a nursing perspective on cultural competence and adopt a definition from Leninger, which states that cultural competence is “[an] in depth awareness of different cultures so that the provider can be knowledgeable about the client’s cultural background in order to provide culture specific care or some universal (common human) care needs” (1989:4). These authors also introduce the concept of “ethnic competence,” originally attributed to Green, which emphasizes “the acceptance of ethnic differences in an open, genuine manner, without condescension and without patronizing gestures” (1982:53-39). Providers that practice ethnic competence acknowledge the integrity of each culture. In doing so, they shed catch phrases like “a culture of poverty” and accept that each culture is rich and complex in its own right (Green 1982).

Brach and Fraserirector extend the traditional boundaries of cultural competency and frame their definition within the language of social justice, describing it as a potential mechanism for protecting rights and improving health outcomes for minority Americans (2000). Since culture is known to influence health care beliefs and choices, a “one-size fits-all” health care system can no longer adequately serve a diverse nation. The authors urge the medical community to go beyond “awareness” and “sensitivity,” when they write, “Taken one step further, the term *cultural competency* has been used to refer to an ongoing commitment or institutionalization of appropriate practice and policies for diverse populations” (2000:183). The concept of cultural competency must respond to the diversity of populations, which requires constant adaptation. Brach and Fraserirector

argue that this requires viewing competency as a continuum, in which the effectiveness of individual and institutional responses to diversity can vary. Such a continuum, is illustrated below.

QuickTime™ and a
decompressor
are needed to see this picture.

Figure 1: Continuum of Cultural Competency. Adapted from “Quality Health Services for Hispanics: The Cultural Competency Component” by the National Alliance for Hispanic Health. 2001.

This continuum sets “cultural proficiency,” rather than competency as the ultimate goal, while cultural destructiveness is posed as the polar opposite of proficiency, framing the six levels of progressing competency. This model can be used to evaluate the status and progress of cultural competency efforts in a particular setting. We must now ask, what does the continuum between a primarily white, ethnocentric, and “culturally destructive” healthcare system and one characterized by cultural competency and proficiency look like in practice? This project will attempt to interpret the narratives of participants with this continuum in mind, as seen in chapters 4 and 5.

In pursuit of a cultural competence framework, Betancourt, et al. address two very practical questions: what are the major components of cultural competence? And how do we incorporate culturally competent interventions into the delivery of health care? (2003:294-295). After reviewing barriers at the organizational, structural and clinical levels, the authors suggest a variety of interventions. These include the diversification of leadership and workforce, alteration of structural processes including interpreter services, referral processes, health promotion and interventions that are culturally and linguistically appropriate, cross-cultural curricula for providers and information on the beliefs and behaviors of the populations they serve (2003). Additional techniques to expand cultural competency include cooperation with community health workers and traditional healers, the inclusion of family and community members in care, and cultural immersion experiences for health care workers (Brach and Frasierdirector 2000).

A policy statement from the American Academy of Pediatrics (AAP), *Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy* makes six recommendations in the areas of medical education and policy, including development of curricular programs at all levels to address issues of cultural competency, cooperation between pediatricians and others in generating policy, pursuit of government funding, creation of incentive programs, encouragement of second language proficiency in medical school, and supporting the leadership of pediatricians in advocating for culturally effective care (2004). It must be noted, however, that none of these techniques can function in isolation. An approach that successfully responds to mandates for improved competency must be all encompassing. This requires the coordinated efforts of all stakeholders and support from the government in terms of finances and infrastructure.

Unfortunately, such a coordinated effort does not yet exist, and as Betancourt et al. note, there remains a thriving debate over how to best operationalize this “critical yet broad construct” of culturally competent care (2003: 294). At present, much is left to the imagination of health care providers.

Cultural Competence for the Latino Community

The U.S. Census Bureau data projects that by the year 2050 “minority” populations will constitute nearly 50 percent of the total U.S. population (Mead et al. 2008:13 Chart 2-2). This demographic shift is both literally and figuratively changing the face of America, a change that demands concurrent changes within the healthcare system. The authors of *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*, warn that unless racial and ethnic healthcare disparities are addressed today, the Americans of tomorrow will face very poor health outcomes (Mead et al. 2008). The need for a model of cultural competency is more pressing now than ever before. Researchers and healthcare leaders must cooperate in the formulation of policies and practices that are attuned to the needs of the racial and ethnic populations they serve.

According to the 2010 U.S. Census, Hispanics constitute the largest minority population in the U.S., at 16.3% of the total population (Lopez 2011). According to current predictions, the Latino population will exhibit the most dramatic growth in the coming decades, and is expected to double between 2000 and 2050 (Mead et al. 2008). According to the Pew Hispanic Center, census data from Massachusetts demonstrates 46% growth in the Hispanic population between 2000 and 2010, a trend is projected to continue (Cohn 2011:Table 6). In addition, this population group is much younger than other ethnic and racial groups, with a median age of 26 years compared with 39 years for

the white population (Mead et al 2008: Chart2-7). In 2009, 22.5% of children between 0-17 years of age were of Latino origin (Childstats.gov 2011: Table POP3). Since the Great Recession of 2007-2009, the spread of poverty has disproportionately impacted this demographic group. With 6.1 million Latino children living in poverty in 2010 (37.3% of all poor children), this is the first time in United States history that the largest group of poor children was not white (Lopez 2011).

I would like to take a moment to clarify some terminology. Throughout this research, the term “Latino” is used, although “Hispanic” is also accepted (Flores et al. 1998). These terms include all persons living in the U.S. with origins in Spanish-speaking regions of Latin America, including South and Central America, the Caribbean and Mexico. Although Hispanic is the official term used by the federal government, Hispanic and Latino are often used interchangeably. I have chosen to use Latino throughout this research, as in other studies of cultural competence, as it may be considered more inclusive and less focused on the influence of Spanish colonialism in these cultures (Flores et al. 1998:1120).

I have chosen to focus on the experiences of Latino families because they represent a large proportion of the families cared for in the inpatient wards of urban hospitals throughout the country as a result of their low median age and high population growth rate. Additionally, research shows that Latino families are present in acute care settings at disproportionate rates as, “too often patients delay medical care until their conditions worsen and necessitate immediate attention” (Peterson-Iyer 2008). Peterson-Iyer suggests possible causes for this difference including poverty, poor access, and cultural factors, such as the belief that one should tolerate pain without complaint. The

unique experiences of poverty, immigrant status and discrimination add to the complexity of the health care needs of Latinos. There is a great need to research, understand, and accommodate the specific linguistic and cultural needs of Latino families in order to create a more equitable and accessible approach to pediatrics.

In recent years, researchers have begun to explore the numerous access barriers Latino families face. These families experience great inequalities in accessing and financing care as Latinos represent 13% of the U.S. population but 25% of those Americans without health insurance (Betancourt, et al. 2003:294). Amongst those with access to health care, language is the most commonly cited barrier to quality care (Flores et al. 1998:1123). Betancourt et al. cite data from the Commonwealth Fund, which states that “language differences present a problem for 21 percent of minority Americans receiving health care” (2003:189). Betancourt et al. elaborate on these difficulties at length. Limited English proficiency (LEP) has been associated with “fewer physician visits and reduced receipt of preventive services, even after controlling for such factors as literacy, health status, health insurance, regular source of care, and economic indicators” (2003:189). In addition, language barriers pose threats to the physical health of patients, as Betancourt et al. explain:

Spanish-speaking patients discharged from emergency rooms are less likely than their English-speaking counterparts to understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care; less likely to be satisfied with their care or willing to return if they have a problem; more likely to report problems with their care; and less satisfied with the patient-provider relationship (2003:296-297).

These basic components of care can have disastrous long-term implications for patient health and often go unreported. Also, a weak or non-existent patient-provider relationship, which is central to quality care, can have implications for

trust and patient compliance. These negative outcomes are not limited to adult patients, as Latino parents have also reported negative consequences manifested their children's health, resulting from the inability of medical staff to speak Spanish. These include poor medical care, misdiagnoses, and inappropriate prescriptions (Flores et al. 1998).

Flores, et al. provide an in-depth exploration of the barriers faced by Latino families in accessing pediatric care within an urban Boston hospital, a context similar to that of my own research study (1998). The authors note the dearth of research on access barriers to health care for Latino children and the limitations of previous research. Flores and colleagues specifically note an inadequate focus on the importance of barriers associated with language and culture, which creates a space for my research. The survey administered by Flores et al. asked parents to name the single greatest barrier to health care for their children. The most commonly cited barriers included language problems (mentioned by 26% of parents), followed by long waiting times (15%), lack of medical insurance (13%), and difficulty paying medical bills (7%). A second question asked if one barrier had ever prevented them from bringing their child in for care. Parents cited transportation (21%), followed by inability to finance health care (18%), long waiting times (17%), lack of health insurance (16%), and a lack of cultural understanding by medical staff (by 11%). While only 1% cited the caregiver's understanding of the parent's culture as the single greatest barrier to accessing care, "About 1 in 9 parents said that they had not brought their child in for care in the past because medical staff did not understand Latino culture" (1998:1123). The

researchers do not hypothesize whether this is an issue of practical misunderstanding, discomfort, or lack of trust, however, this is especially relevant to research in cultural competency, and inspires questions of how this barrier can be overcome.

This account of access barriers is enriched by its consideration of the normative cultural values held by Latino families that may be lost in translation during the interactions between providers and families. These include *simpatía* and *respeto* (Flores et al. 1998:1123). *Simpatía* values politeness in stressful situations and avoidance of confrontation. *Respeto* presupposes respect for authority figures such as doctors. Importantly, *respeto* also implies a reciprocal relationship in that patients who assume this attitude toward health professionals expect the same degree of respect in return. These two values only scratch the surface of the type of understanding that is needed to both eliminate misunderstanding in the provider-patient exchange and approach cultural competency and proficiency. Other cultural norms described by Peterson-Iyer include *personalismo*, or the value of a warm, personal interaction; *familismo*, which emphasizes family obligation and loyalty to the extended family; and *fatalismo*, or the belief that individuals have little control over their fate (2008). While it is important that physicians be familiar with these concepts, Peterson-Iyer makes an important point regarding generalizations, which often plague efforts at cultural competence:

[These concepts] are a starting point, not an ending point; in other words, they call practitioners to look more deeply into the particular cultural, linguistic, and socioeconomic contours of their patients' backgrounds and to open themselves to alternative ways of understanding and interpreting their patients' actions and requests. The point deserves emphasis: Health care providers must be cautious not to oversimplify the values, customs, and

beliefs that characterize any ethnic group-especially one as heterogeneous as Latinos (2008).

Healthcare professionals must seek a balance between an awareness of the shared cultural values amongst the Latino populations they serve, and recognition of unique factors in each individual context. Peterson-Iyer envisions a model of cultural competence in which practitioners adopt a stance of “cultural humility” defined by their openness and awareness of each individual’s cultural lens (2008). I have designed and conducted my own research with this vision in mind. In chapter five I will use provider reflections to illustrate their search for a balance between cultural and individual factors in a spirit of humility.

In this brief review of the literature on culturally competent health care, I began with a discussion of racial and ethnic inequalities in care. My argument is rooted in the belief that health care is a fundamental human right, a right that is not being adequately protected. Culturally competent health care is a paradigm introduced to correct the unjust racial and ethnic disparities in health care. While the overall philosophy of cultural competence is an important step toward equal access, the lack of a concrete model has impeded widespread actualization of this philosophy. Researchers have begun to examine the efficacy of a broad range of interventions, however there is much to be done. In this research, I examine the cultural competence of care for Latino families at Boston Hospital. I have presented literature that reveals the barriers faced by this group and highlights their need for improved care. I have designed and conducted my own research with the limitations and questions raised by existing research in mind.

Chapter III

Methods

Storytelling

Stories are an important lens through which we can understand the human experience. Through this research I sought to tell stories. The stories of patients should be considered by the medical community in order to understand their experiences navigating a complex and bureaucratic system during periods of health and illness. The stories of health care providers are just as important in understanding the medical encounter and the broader healthcare system. Despite their importance, these stories are rarely told and even more rarely are they told together.

Medical anthropologist Arthur Kleinman works with an explanatory models approach that “tries to understand how the social world affects and is affected by illness” and complements the “expert” knowledge of providers with the patient’s own illness narrative (2006:1674). This transforms the medical interview into an opportunity for a clinician to perform a “mini-ethnography” in which he or she can come to understand the ways in which culture and experience inform the patient’s viewpoint. By weaving together the complimentary narratives of patients and providers as Kleinman proposes, I hope to create a more comprehensive representation of the experiences of Latino families within the health care system.

We are all storytellers, telling our own stories in various forms throughout our lives. In this project, I sought to convey some of these untold stories in a way that would make them accessible to the wider medical and academic communities, and especially to health care providers that work closely with the Latino population. While my sample size is too small to generalize about the overall experience of Latino families at Boston

Hospital or the medical providers who care for them, I attempted to draw forth the common themes that exist within these stories and paint a picture of the challenges that these two different groups face, with special emphasis on the cultural overlays that impact their experiences.

Research Site

The pediatric inpatient units at Boston Hospital served as an appropriate research site for multiple reasons. As a national leader in hospital care, the challenges and efforts toward cultural competence seen at this study site should be, to some extent, representative of a larger group of high-quality hospitals throughout the country. The staff members I encountered during my nine months at Boston Hospital were both talented and passionate about what they do. That being said, this hospital may not be representative of the degree of cultural competence in an “average” hospital setting. In addition, Boston Hospital serves a diverse patient population and is continuously confronted with issues of cross-cultural health care. The in-patient pediatric wards were an ideal research location, as they are relatively small and contained, with a dedicated staff that is highly knowledgeable in pediatrics. There is a relatively quick turn-around of patients on the wards, which offered a dynamic research population. In my work with both Latino families and the medical staff of the pediatric in-patient units, I sought to give voice to both groups, portraying the two sides of a power differential that is studied through a sociological lens relatively infrequently.

Sampling

This research focused on two major groups: health care providers that work in the pediatric in-patient unit of Boston Hospital and bilingual Latino parents of children on

the in-patient units (both the inpatient unit and the pediatric intensive care unit, or PICU). My sampling method was non-random and was based largely on the recommendations of the medical staff I worked with as a research intern at Boston Hospital. I recruited employees of Boston Hospital via email or in person communication. In order to pinpoint parents who were potential subjects, the unit's attending physician identified all bilingual Latino families on the unit. This allowed me to approach each family, explain the study, and ask if they would be interested in participating.

I chose to focus on the experiences of parents speaking on behalf of their families, as their perspective provided a particularly rich insight into the experiences of the Latino population as a whole. Especially within the Latino community, decision making on matters of importance, including health, may involve the immediate and extended family. So, parents, grandparents, and other extended family could offer insights into the entire family's experience within the health system. This sample included only those families who were able to conduct the interview in English, as I was not able to make use of interpreter services for this research. Due to the fact that this small sample was based, to some extent, on convenience and accessibility, the generalizeability of this research is limited.

Data Collection

My overall methodological approach was to create an ethnographic account of the provision of care for the Latino population with attention to the provider and patient perspectives. I chose a qualitative, inductive approach inspired by ethnographic methods, as I was most interested in the experiences and attitudes of the provider and patient communities within the hospital environment. While I sought to examine the status of

culturally competent care in this setting, I was more concerned with collecting and interpreting accounts of individual experiences, rather than relying on quantitative data collection.

Since this project focused on such a defined setting and sample population, it can also be viewed as a case study, which is considered “useful for exploring the subtle interaction among variables and observing causal processes at work, generating outcomes” and lent itself to the desired outcomes of my research (Lipson 2005:101). The broader approaches of ethnography and case study were accomplished through the specific methods of participant observation, and semi-structured interviews.

One method I used was participant observation. My positionality as a researcher within this setting was as follows. I gained access to this hospital environment by working as a research intern in the pediatric hospitalist division, beginning in June of 2011. I worked under the head of the division and another doctor who conducts her own quality improvement research within the unit. During the summer I became familiar with the hospital environment as I assisted with projects and shadowed the medical team during rounds and interpreters as they worked throughout the hospital. I assisted with a quality improvement project that explored the interaction between the medical team and interpreters in providing care during rounds to LEP families. Throughout the process of conducting the research presented here, my supervisor served as a facilitator and co-investigator. She helped me to establish credibility as a researcher and to understand how the hospital operates.

While acting as a participant observer, I joined the medical team on rounds and spent a substantial amount of time shadowing doctors on the floor to further develop my

sense of the relationship between patients and providers. This method also helped me to understand aspects of cross-cultural interactions that might not be evident in the interviews, and to appreciate the interaction between the many parties involved in providing care for each family. It must be noted, however, that participant observation is a method that is highly subjective and could be affected by my lack of expertise in the biomedical and/or Latino cultures.

My primary method of data collection was the semi-structured interview. I conducted 20 interviews in total; 14 interviews with various members of the medical team including attending physicians, residents, nurses, social workers, and Spanish-speaking medical interpreters, as well as 6 interviews with seven parents of pediatric patients, all of whom were Latino and bilingual. Within this cohort, I spoke with one couple, one father, and four mothers. Five of the providers I interviewed identified as Latino and represented a variety of nationalities. Of the six families interviewed, four were Puerto Rican, one was El Salvadoran, and one was biracial (Cape Verdean and Puerto Rican). Providers identified Puerto Ricans and Dominicans as the major subgroups within the Latino population at Boston Hospital, although unfortunately I was unable to speak with any Dominican families.

I have a personal interest in working with Latino families because I am most familiar with their language and particular health needs from my own experiences working in a community clinic in Nicaragua. However, I was only able to include bilingual families, as my language skills are not strong enough to enable me to conduct interviews in Spanish. As I could not acquire an interpreter for all of the interviews, I chose to I conduct all interviews in English. My choice to conduct qualitative interviews

allowed me to explore the attitudes and perceptions of all parties involved in depth, drawing on particular stories and experiences. The interview questions were tailored to the particular subpopulation, whether medical provider, interpreter, or parent of a patient. In general, these questions sought to uncover the interviewee's experience of cultural competence in pediatric care and their own critical evaluations, with the understanding that such evaluations are rooted in their experience. Through these interviews I also sought constructive ideas on how cultural competence could be improved and higher quality care achieved. These interviews focused on general care practices and doctor-patient encounters, and did not involve a discussion of private medical information.

Chapter IV

The Patient's Voice

Encounters with the American health care system can be bewildering for any family, thrust into a world of specialists, medical terminology, procedures and medications, as they worry about the wellbeing of their sick child. These feelings of confusion may be magnified in the experiences of Latino families, in particular, immigrants and those with low English proficiency who are often marginalized by the medical establishment. These sorts of experiences are not widely known because such families may not have a voice in the medical institution or in society at large. Parents in Latino families may not share their stories with their health care providers because they might lack the ability to express themselves due to a language barrier or time constraints, feel their story does not matter, or they may not share simply because no one has ever asked them to.

In this chapter, I will rely on the wisdom of these parents by using their own words whenever possible to characterize the patient experience and the barriers that they constantly struggle against. In some cases, I will use the words of the nurses, doctors, social workers, and interpreters that work closely with these families in order to flesh out some aspects of the stories that the families did not discuss explicitly. Using the accounts of providers allows me to supplement my small sample size and adds diversity and richness to my data.

Something I should reemphasize is that most individuals often do not view their “culture” as such, but instead as the norm. In some ways, asking a person to describe his or her own culture is like asking a goldfish to describe water – they may struggle to

articulate this ubiquitous aspect of their lived experience. One staff member made an important note about cultural self-reflection:

People don't think of their culture as their culture. They think of it as their own personal things. So, like, I probably do cultural things from the way I was raised, but I don't think of that as "culture" ... So I think that, like if you go to someone and say "what are your cultural issues?" they don't know because that's just them.

As a result of this fact, much of my analysis of culture will be embedded in the conversations I had with patients rather than in overt commentaries on cultural values.

The embedded nature of these cultural reflections holds implications for cultural competence and indicates its complex nature.

Barriers to Care

I will begin by broadly sketching the major barriers to care faced by Latino families at Boston Hospital by using the story of one family's experience, as recounted by a member of the medical team. The story is as follows:

A young couple brought their two-year-old daughter in to the hospital. She was very sick and nearly died during her stay. The parents were in their early twenties and were undocumented immigrants from Paraguay who had grown up in a small village. The provider retelling their story described the parents in the following manner:

[T]hey were very, very sweet, but very soft-spoken, very shy... they're not the type that is gonna come and be, you know, asking a ton of questions. They grew up just knowing to follow orders and not really ask too much, and just do what you're told, and they really did put *all* of their faith in the doctors and that was that... They were *so* upset, they were sobbing every time I talked to them they were so nervous about their baby...

Fortunately, the child's condition improved. However, the parents continued to keep their distance and appeared to be disengaged. As they were not feeding their daughter or participating in her care in the way that the medical team expected them to, and the

nurses became frustrated and assumed that the parents wished to be uninvolved. The team was unsure of how to address the situation, but soon enough they realized that the parents didn't really understand what they were being told. The health care provider who recounted this story soon realized the cultural roots of the problem and worked out a solution:

[T]heir whole culture... they had grown up to just not be that way, and in their mind, this was the right thing to do, like, "here's the medical team. They're taking care of our daughter." And they wanted so badly to hold her and to feed her, but they felt like "Until they actually look at us in our face and say, 'Now you're gonna hold her,' they didn't feel like it was their position to do that... So... I realized this and I had to tell the nurses, "This is actually what they *want* to be doing but they're afraid that they're going to be understood to be disrespectful of the medical team and the care that they're providing.

This case shows the complexity of each patient experience and the variety of factors that come into play, many of which were not initially evident to the medical team. In this family's case, there were multiple barriers that the medical team had to overcome in order to provide quality care that was sensitive to their culture and unique experience. The team had to consider the impact of the family's language ability, health literacy level, immigration status, and cultural beliefs about respect toward doctors and other members of the medical team. The nurses who assumed the parents were disengaged with their child's care needed to understand the family's story, complete with its many layers, in order to connect with them and ease their worries. Without an understanding of the family's culture, a family such as this might be mislabeled as non-adherent by the medical staff. In a more severe situation, they could be deemed unfit to care for their child, when in fact their cultural background led them to simply be cautious and unsure within a foreign system.

This case exemplifies many of the barriers faced by Latino families in similar situations, as explained by one of the Spanish language interpreters:

[A] lot of them don't understand how the system works... the language barrier of course is another issue because they don't understand too many things and because a lot of the letters they get are in English and **they're just trying to survive day to day** because they... I guess have a lot of disadvantages with employment... or maybe it's the legal immigration status... So any little thing, maybe if the car breaks down, they don't have money to rent a car or take it to the shop right away... maybe they work these jobs where they just get really taken advantage of... so they can't request a day off as they would wish to or need to...

As captured by this statement, each family may face a variety of barriers manifested in concrete, daily experiences that make health care less accessible on many levels. They may be unable to access care due to issues with transportation, lack of work flexibility, or the cost of medical care. They may not understand the purpose or risk of certain procedures, discharge instructions, or dosage information on prescribed medications. There are seemingly innumerable factors that can tip the scales between understanding and miscommunication, between a sense of inclusion and exclusion, and between making ends meet and failing to do so. These factors inevitably impact the health of children and families and should be understood by their health care providers. Other less concrete barriers can also exist, such as the struggle to navigate a system that feels inaccessible.

Another interpreter elaborated on these barriers:

One of the reasons is because of economics. A lot of the Latino population here, they are very low income. There's an issue of [being] underinsured or semi-insured... There's some other issues... the cultural part of it and the economics, cultural because of how systems work differently in other cultures and other countries and perhaps also, the lack many of these people had back in their countries... so just by coming here and having to face a whole health care system that's gigantic, it's just so much for them.

This feeling of intimidation by the immensity of the healthcare system is a challenge

faced by many minorities and immigrant groups, including, but not limited to the Latino population. This sense of cultural inaccessibility ought to be kept in mind when working with these families and should inspire an increased focus on cultural competence. Now that I have introduced a few broad-based barriers to care as identified by medical staff, I will examine a few other predominant themes as expressed by the families themselves.

Stress

Each family I interviewed had a child in either the pediatric inpatient unit or the pediatric intensive care unit (PICU) and felt a great deal of stress related to their child's condition. However, each family endured different stressors and expressed their experiences differently. One mother, who I will refer to as Adriana, underwent a particularly difficult extended stay in the PICU and spoke of her experience with stress:

I don't know it's just like... because I'm going through all this ... I'm livin' this, you know what I'm saying? I'm going through all this and nobody pretty much knows what I feel. Like I could come in here and have a smile, like I have a smile and nobody knows how I feel on the inside and just because they ask me how I'm doing, yeah, I'm ok, I'm not excited, I'm not that good. I just have to be... I have to still have a smile on my face because I have a daughter that's seven...

It is difficult to explain the frustration and sorrow in this mother's face as she talked with me. Adriana continued to describe her relationship with the nurses and other medical professionals saying, "I like them. They're supportive, but I'm just saying... it's wicked hard. Nobody understands. Nobody knows." Adriana's words communicate her sense of isolation, which only compounds the stress of having a child in intensive care. Other mothers echoed similar sentiments, including a mother with a child in the in-patient unit who reflected on the stress she feels from a cultural perspective:

I think we [Latinos] get very concerned. I mean, when the doctor mentioned kidneys and serious inflammation and probably damage... we,

the Latino culture, we react very strongly to that. We get very confused... and we just start thinking the worst and hoping that everything is going to be getting better. We just get overwhelmed about the whole thing.

Like this mother, any parent feels a great deal of stress surrounding the hospitalization of their child but this may be felt more poignantly when coupled with a low level of health literacy or distrust of the medical system. Such a situation requires a more responsive medical team that can work with overwhelmed families to dissipate their confusion as best they can.

Language barrier

The language barrier is probably the most obvious challenge faced by families that either feel more comfortable speaking Spanish or speak Spanish exclusively. Feelings of stress and confusion experienced by families on the unit are often associated with the language barrier and communication issues. Despite the importance of this barrier, it is often underestimated.

While I only spoke with bilingual parents, many of them relayed the experiences of their family members who struggled to communicate in English. These patients experience confusion, shame, and are sometimes subject to discrimination in their encounters with the healthcare system. I will use the words of one Salvadoran mother, who I will refer to as Teresa, as she reflects on her parent's experience to illustrate the challenges that many low-English proficiency patients face. Confusion and discomfort were the resounding themes in her reflection:

It's very difficult for them... even though they have a translator they can still get confused... and they just don't ask the questions... I think they feel more comfortable, depending on how comfortable the translator makes them feel at that moment, but I think it's not easy to have someone else that you don't know and you just don't know how they're translating and how they're giving you the information...

After her father was diagnosed with kidney cancer, she described his intensified sense of confusion and discomfort in each medical encounter:

I can see him having more questions, confused and concerned of course... the translator [has to] to make sure they [the providers] understand, and to understand about the culture because sometimes, you know, like my dad won't ask any questions and he's very quiet and he's holding everything back so I think the translator has to be insisting, "Did you understand? Do you have any questions? Did you understand this part?" ... Encouraging them to be more open and ask... My dad... sometimes he's very shy about expressing certain areas of his body and how he feels and sometimes they don't disclose that.

This experience demonstrates just how much may go unspoken during a medical encounter, often at the patient's expense. Teresa also hints at how culture as well as personality may play a role in the interaction. This requires a sensitive interpreter who is familiar with an individual's culture and is able to serve as a cultural broker between the patient and provider.

The experience of Teresa's mother highlights the link between language and health care access, another troublesome challenge for many Latino families. She explains:

There are some doctors that don't provide translators and sometimes it becomes very difficult... [T]here was a doctor for my mother and it became very difficult for me to go to every appointment and translate and the doctor just decided to completely terminate the care because she had missed like two appointments that I wasn't able to go with her, and he wasn't even listening to me. He just cut her down and didn't even offer her a translator...

While this event did not take place at Boston Hospital, it is a good example of the discrimination that many families face based on their language ability, which, in turn, impedes their access to high quality care. This is an example of cultural incapacity as the provider was completely insensitive to the linguistic needs of the patient in a manner that

is obvious. However, in most cases discrimination based on language is often more subtle. Nevertheless, such subtle forms of discrimination can have major consequences for the patient. One interpreter captured this well:

[S]omebody looks at an immigrant and because they don't speak English... [the provider] may think this person has less intellectual ability or... because a person doesn't make it to appointments... the American provider might think, "well this person just doesn't care" and ... sometimes, I guess that can happen subconsciously... they might start talking down to a patient or... let their frustrations show, even though the patient's not trying to be careless, they just have so many issues going on that a regular American wouldn't face... So, even though providers are trained to...treat them more on an equal level...sometimes the doctor has a lot of things on his mind or has a lot of patients...

While the difficulties posed by the language barrier will be further considered in chapter five, it should be noted that these difficulties are at the core of the culturally competent medical encounter. Communication is dependent on many factors and involves a number of individuals. Therefore, something as small as a single word can break down the sense of understanding and trust between the family, provider, and interpreter.

Family relationships and extended family

Latino families in the in-patient units of Boston Hospital often have large families with siblings, parents, grandparents, aunts, uncles, and cousins that pass in and out throughout the child's stay and who are involved to varying extents. This means that family leadership may assume a different style than the providers are familiar with and there could be multiple members of the family involved in making decisions regarding the child's care plan. These relationships are often complicated by gender roles, hierarchy, and varied levels of language ability, complexities that are not immediately evident to the family's providers.

The families that I spoke with often mentioned visits from their extended families and the role of these relatives in their child's care. One mother commented on her own mother's high level of involvement:

Each one has their own opinions, like my mom's constantly calling me and coming into the hospital and making sure we're eating... and she will keep calling and asking questions about her [granddaughter's] condition... ... That creates a lot of stress and that's how we [Latinos] are, we're constantly wondering, more than we're supposed to.

This experience is common to many families, whether Latino or not, although it resounds with the theme of *familismo*, which is well documented in cultural competence literature.

Families are dynamic structures and each is informed by individual personalities, the "culture of the family" itself and the wider culture the family is a part of. It is nearly impossible to know the personalities, power dynamics, and values of a particular family without spending a significant amount of time with them, which is often difficult in the hospital setting. It is important to emphasize how unique each family is, with various "quirks" and cultural influences that inform their story and hold implications for the child's care. There are a variety of dynamics that are invisible to a provider at first, but may be essential to providing care for a family and therefore must be uncovered throughout their interactions. It is important that providers show interest in learning about how these families work, as this may provide valuable insights into the medical encounter.

Faith and spirituality

Parents of patients often mentioned a strong sense of Christian faith characteristic of the Latino population. One Puerto Rican father in the PICU commented, "It's [Christianity is] just the way we were brought up, you know?" This comment was echoed

in other interviews with families, showing how a strong sense of faith and religious commitment is bound up in the cultural identity of many Latinos, influencing their perspectives both on life and on sickness. For many parents that I spoke with, their faith was more of a relic passed down to them from their grandparents than something that they actively practiced, although it was certainly still a part of their own perspective. For others, especially those in the PICU, faith is integral to their ability to cope with and make sense of sickness and death. Below is an excerpt from a conversation with Adriana, a Puerto Rican mother in the PICU, quoted earlier in this chapter.

Mom: My mom, she's very supportive, she's like, "Oh, we have to have faith in God" things like that.

Author: Do you think that's how she approaches sickness? Is faith a big part of it for her?

Mom: Well for us, it is. You just have to have faith in God, but... we didn't know this is something new to us. I never knew that babies could develop this thing my baby had... I didn't know. I heard about down syndrome and things like that but I didn't know... what was a G tube until I came here and they told me, "Oh we're putting in a G-tube" and I'm like, "what's a G-tube?" but it's like a feeding tube and they told me all this and I'm like, what's that?

Author: Do you think your faith is something that helps you and your family when you don't know what's going on and when you don't understand everything?

Mom: Oh it really does. It helps me. But that's how we grew up, having faith, you know? ... They even asked me, one doctor he asked me, "Oh have you seen miracles before?" And I'm like, "It could happen." Like, it could, tomorrow... I told the doctor and she was like, "Oh, really?" and probably she thinks I'm crazy but I'm not.

This family's case is particularly difficult and faith has played a prominent role in Adriana's ability to cope with the situation at hand. She seemed bewildered by her child's complex medical situation and she and her mother turned to their faith to make sense of

things that were completely foreign to them. One of the medical professionals shared her insight into the faith common amongst Latino families and its influence on the medical encounter:

I think faith is obviously a really great thing and if it brings them hope I think that's good...[I]t can start to be a little problematic when we have children who are really sick, who don't have a good prognosis and it's really difficult to ... just respect the fact that a parents says, "I need to have faith in God. God is going to take care of this," Or, "I need to hope for a miracle" And that, again, is not just a Latino thing, but it is something that happens a lot with Latino families because they are so faith-based, and you know, you have to respect that.

This perspective shows how a more fatalistic approach to faith can cause conflict between the family and the medical team, especially in complicated cases involving end-of-life issues. While this provider correctly notes how faith and spirituality are not limited to the Latino patient experience, it is certainly embedded in the cultures of many Latino families and shapes their experiences in a way that should be considered by their health care providers.

Alternative medicine and folk remedies

Much like spirituality, the use of alternative medicine and folk remedies are often inherited from previous generations. While most of the patients I spoke with did not report significant experiences with alternative medicine, some mentioned family traditions or remedies in passing, often as suggestions their older relatives made in response to their child's illness. Those who use remedies as compliments to their regularly prescribed medicines often wrote them off as something illogical, unscientific, and tied to tradition, however, these remedies seemed to be integrated into their approach to health. Also similar to spirituality, these alternative medicines are, from the perspective of these families, just another element of "how we were raised." One Latino

provider captured it well when he said, “People are going to do what their grandma tells them to do no matter what the doctor says.” The following conversation with a father, who I will refer to as Marcos, demonstrates this attitude:

Marcos: There are remedies. There are certain things that grandparents do, especially grandmothers. They always like a concoction.

Author: Have her grandparents tried to give [your daughter] anything?

Marcos: No, but for example, you know, if you get bumped on the head... you would think to put ice on it, but the one thing that we have is to put butter and salt. And, I mean, it works. It makes the swelling go down pretty fast... So there's plenty of grandparents that have these different concoctions from Puerto Rico and different herbs and stuff... They really... do help and I don't know the actual... science behind it, you know, but it really works.

Author: Do you ever use any?

Marcos: My grandmother used to have a certain cough syrup and I didn't know what it was made of, but it stank and it tasted horrible but about an hour later I was clear as a whistle and it's just like I said... you know, it's those things that I'm pretty sure if a doctor heard what they're made of they'd think that's horrible and stuff...

Marcos, a man who was born and raised in the United States, is in a common position among Latinos who may make use of folk remedies embedded in their native cultures. While he trusts in the healing ability of his grandmother's remedies, he also recognizes that they are unlikely to be accepted within the American health care system. He hints at the disapproval that he would expect from a doctor in response to such a treatment, which is similar to the skepticism Adriana perceived in response to her belief in miracles. It is important to recognize that although these practices are not universal within the Latino population, they may be an unspoken element in a patient's attitude toward their health care, or a detail overlooked in the admission interview.

A Cape Verdean mother with a Puerto Rican husband, who I will refer to as Linda, reflected on attitudes within their Latino extended family, and began to get to the root of *why* culturally based alternative medicine remains a part of the Latino patient experience. In the following excerpt from our conversation, she describes a variety of practices and the roles they play in her family's life.

Linda: They believe in Buleria... It's like when they go see a witch doctor type of thing and they get herbs and like when [my husband] gets a cold his grandmother from his dad's side always gives me this tea... she puts like whole cinnamon and a whole lemons and leaves and they use herbs and you go see this... and you feel sick and this guy he'll make you feel better. They'll use witchcraft to take that off... My aunt sees one and she thinks it helps...It's not that I don't believe in it, it's that I think it's all in your head. And if you believe in it, you know, it might [help] because you believe in it.

Author: Do you think that gives people a sense of comfort, being far away from home?

Linda: Yeah, and hope.

Although Linda herself does not necessarily subscribe to these practices, which she refers to as Buleria and "witchcraft," she recognizes their importance to her family members who believe in their ability to heal. She also touches on the possibility of the placebo effect and the role of the mind-body connection in the use of these remedies. The hope that she mentions is an especially intriguing insight into why patients might continue to practice remedies their grandmothers used. It seems that these remedies offer something that western medicine simply cannot, as they connect a past of family tradition to a hope for future health. A Latino provider further reflected on the origin and importance of these remedies to his patients when he said:

I think the main reason for all these folk remedies is... [a long time ago] there was no such thing as going to the doctor. You had to cure it yourself at home with whatever there was... [T]here was just no access to

medicine... so you had to just deal with it at home... [T]hose things just permeate through culture, even though you go to the doctor and even though now there's free health care... [S]ome of my patients are like... '[S]ometimes I don't trust medicine because all these studies come out that say one thing and ten years from now they'll say something else and five years later they'll say something else, but what I *do* know is that root of 'blah blah' has been curing my family for centuries.' And how do you debate that?

From this commentary it seems that although folk remedies may have arisen from situations of material need, they now provide a sense of comfort and constancy for those navigating an unfamiliar health system, facing seemingly inconsistent scientific information. This provider also alludes to the role of tradition in the use of such remedies. They are so embedded in one's culture and tradition that they deserve a degree of respect, a respect which providers may not be able to provide unless they are aware of the remedy and its cultural basis.

Attitudes toward the health care system

Despite the multiple unique challenges that each of these families face in obtaining quality health care that is sensitive to their linguistic and cultural needs, as a group they expressed an overwhelmingly positive attitude toward Boston Hospital and the American healthcare system as a whole. When asked to describe their experience in the American health system, as opposed to in their native countries or the countries of their parents, most expressed how much better it is here. Marcos commented:

There is a huge difference from the health care in Puerto Rico and the health care here. A *huge* difference... the waits, the reaction of doctors... Over there it's completely different.

One mother commented:

Everybody there wants to come here when you're sick. I don't know why but I think it's because in Puerto Rico... medicine is not checked... you

say, ‘Oh, I have a hurt in my chest,’ and they give you a prescription and they don’t check if you have something wrong.’

A second mother simply stated, “Oh yeah, here it’s better. There you die.” Although one mother expressed that older family members often feel more comfortable returning to their native country for care, the general consensus was that in the United States, care is of higher quality, is safer, and is more desirable. Whether or not the allegations these parents raised against their native health care systems are true or based on second-hand stories, they inform the way these families approach the health system here, as well as the way they view their American providers.

What makes a good doctor? The patient perspective

Developing a relationship with one’s health care provider is incredibly important to any patient, regardless of their experiences or background. However, relationship building may be arguably more important for vulnerable population groups, including minorities, immigrants, and non-English speakers who often experience more barriers than the average patient. During my conversations with families, I asked parents what makes a good doctor and what is important to them in forming a relationship with their providers at Boston Hospital and elsewhere. Each parent offered their own words of wisdom on the provider-patient relationship, words that should be acknowledged by their providers as, after all, these parents are the “experts” on their own children.

Negative relationships and trust

Teresa, the Salvadoran mother quoted earlier, described an example of an interaction with a nurse during her stay at Boston Hospital, demonstrating how a negative interaction with a provider can potentially set the tone for a family’s experience. She

explained that the nurse and her three-year-old daughter were not connecting or understanding each other, and expressed her own worries:

I felt the pressure, I tried to connect with her and I was not able, so I felt more stressed ... I'm overwhelmed and I want her to get better and I said, "Oh my god. This is not working." And ...one person can completely change how you feel with everyone in the hospital because then I was just like, "Oh my god. Everyone's gonna be like that."

Although Teresa expressed how happy she was with the other medical staff, the pressure she felt as a result of this relationship only added to the other stresses of having a sick child. Teresa's story further emphasizes the importance of developing a relationship with health care providers, as she expressed the frustration that she and her parents felt as they were passed from doctor to doctor while trying to manage her father's kidney cancer. Her words express their need to establish a relationship with their providers and to have a sense of consistency in his care, needs which were stunted by their limited insurance coverage, which forced them to see different doctors at every visit. Teresa explained:

[T]hey're not seeing the same doctor every day and they're not trusting that... You don't know them and you just see them one day and all of a sudden they tell you, "You're going to be having a surgery. This is what we think" and you're like, "Woah, who are you? What's your background?" So that's kind of scary... That's where it becomes difficult when you jump from one doctor to another.

Teresa touches on the central theme expressed by families in terms of relationship building: trust. The inconsistency in her father's care and the abruptness of the physician's communication left them feeling scared and unable to trust in the care they were receiving. Another parent echoed the importance of trust:

I guess you have to build trust with that patient and get to know them and once they get comfortable with you they'll open up and you'll have that doctor-patient relationship... you know, "How's it going? How are your kids?"... Talk about other stuff and that's how you open up, trust you and maybe tell you something they're scared to tell you.

This mother notes how a sense of trust and comfort are built through conversation over time. Trust is especially important in the provider-patient relationship for the sake of disclosure, as patients are more likely to disclose important details about their health that they might otherwise hesitate to share. But how, in the patient's perspective, do you build a trusting relationship with your doctor or nurse?

Attitude

Most parents emphasized the importance of the provider's attitude in building a trusting relationship. When I asked Linda what makes a good doctor, she responded, "Their attitude. The way they treat you from when you come through the door. I think that's what makes the first impression." The provider's attitude has a direct effect on the patient's response. One mother explained this succinctly when she said, "Sometimes the doctor is very serious. You scared to ask something, you know? But sometimes he's a very friendly person and it's very easy to talk to a person like that." In many ways, however, these families responded best to providers whose attitudes exceed mere friendliness and are characterized by compassion. For Marcos, compassion is key to his relationships with providers. When I asked him what makes a good provider he said, "I don't want to necessarily say the attitude, I wanna say the compassion. Just to really feel for that person." In many ways, this compassionate attitude is an innate quality, a dimension of a provider's bedside manner that cannot be taught in a classroom.

Communication

One mother recognized an important truth when she said, "When there's no communication, there's no trust." Communication is central to the relationship between patient and provider. If a parent is not able to communicate their questions and anxieties

to their provider, the relationship between them is fundamentally different. This becomes even more important when technical medical information is being shared and crucial decisions are being made regarding the health of a child. In order to communicate effectively, patients must feel comfortable enough to ask questions in order to understand the situation at hand. Marcos expressed that a good doctor should:

[Leave] you without any questions... You know, sometimes ... there's a question that people have that a doctor wouldn't even think of because what's common sense to them might be questionable to us, you know. So someone who just genuinely cares, and you can tell, constantly updating you, explaining to you what the situation is going on... covering all the bases and just making you feel comfortable and ... not [acting] as if you're interrupting them... like... you're a doctor. This is your job. You should want to work here, you shouldn't make people feel like you could be out doing something better.

Marcos notes the importance of attending to the patient's questions until there is no room for misunderstanding. By taking the time to be thorough, the provider can show a compassion and genuine care for the family's wellbeing. Marcos reflected on the importance of this attention in his family's case:

Some parents they just wanna be sure. And some doctors, it seems like they get really agitated... because, you know, "her arm's not falling off, why are you bringing her to the emergency room if she's just sneezing?" For example, yesterday we brought [my daughter] to ... another hospital, and... the doctor said, you know what, her lungs are fine. She's free to go. We bring her to another doctor and she has RSV and so that's a perfect example, you know, of people that are covering all the bases rather than saying, "Hey, she looks fine. See you later."

It is encouraging to note that the doctors at Boston Hospital took his concern seriously and correctly identified his daughter's condition. Nevertheless, it is distressing to acknowledge how often questions and concerns are brushed aside, potentially leading to negative health outcomes.

A situation like Marcos' can happen to any family, regardless of their background. However, cultural factors may come into play in communicating with families. One mother, Teresa, commented on the type of communication that she believes works best for Latino families like her own:

And I think that's what a Latino probably might need... support to feel more confident because ... we tend to ask more questions than we normally are supposed to... So it's just getting the support and the information that was the thing that was very helpful.

This desire for support, patience, and attention that Teresa describes could very well have a cultural basis. One interpreter described to me how Latin American patients simply aren't used to a system where doctors have fifteen minutes to see a patient, in which they often follow a standardized set of interview questions. They may be familiar with a patient-provider relationship based on an entirely different mode of communication that is the norm in their country of origin. The interpreter then suggested, "Just looking the patient in the eye, just taking that four or five minutes out just to be friendly and just to listen... [T]hat would go a long way."

Teresa spoke for many families when she described the links between trust, communication, and patience that characterize a good health care provider, who should:

[M]ake you feel comfortable and... give you as much information, be patient, and just answer your questions instead of avoiding them or not giving you all the information that is necessary, because if you don't give them all the information the patient is not going to trust you... I know in hospitals there's a lot of patients but sometimes the explanation and the time and the care... I mean, that shows a lot.

These qualities and practices not only make for a good doctor or nurse, they equip health care providers to be culturally competent. Providers who seek out trusting relationships with their patients, practice compassion, and focus on good communication will be able

to better respond to the needs of each family as informed by their culture and experiences. Now, I will turn to the reflections of Latino families on their relationships with Latino health care providers.

Relationships with Latino providers

Although all of the parents I interviewed were bilingual, many of them commented on the benefits of having a Spanish-speaking healthcare provider. While one mother said she did not have a preference and one said she preferred a non-Latino provider, the other parents expressed that both they and their Spanish-speaking relatives preferred to have a Spanish-speaking, Latino provider if possible. In some cases, patients will go out of their way to see a Latino provider, especially if they do not feel as comfortable speaking English as they do Spanish. This cultural and linguistic concordance facilitates the communication between patient and provider that is so crucial. Linda explained, “[I]t’s just easier to communicate. They probably know your culture and know how it is so, I think... it’s much easier when they speak your language and they can relate to you at least on that point.” This commentary notes how language and culture are bound together and how a provider’s knowledge of a language may also confer some cultural knowledge that improves their ability to relate to their patient (although this is not always true).

The unique relationships formed between Latino families and Latino providers extend beyond a mere linguistic compatibility. From the parent perspective, it seems that there is a deeper well of shared knowledge between the parent and provider that forms the basis of the relationship that they form with one another. Adriana reflected on her experience with her OB/GYN who is also Puerto Rican and Spanish-speaking: “We build

this relationship and she does my care good and things like that. Like, every regular doctor, but since we're from the same culture, we *know*." She continued to explain that, "[W]hen somebody's from the same culture, it's more supportive." As I am a Caucasian American, I'm not sure that I can fully understand this sense of "knowing" and support that Adriana feels, as it is based in her own language and culture. However, I think these comments point to a common ground between them- a similar set of traditions, beliefs, and practices. Through the theoretical perspective of symbolic interactionism, this mother and her doctor might share a culturally derived set of symbols or ascribe the same meaning to an interaction. This shared knowledge and common way of seeing the world has the potential to provide a form of support that patients cannot find in relationships with others who lack access to the same well of knowledge and meaning. This complex aspect of the provider-patient relationship will be explored in the next chapter, through the perspective of Latino providers themselves.

This chapter provides a limited view into the diversity of challenges faced by Latino families at Boston Hospital, as well as the patient's perspectives on how their relationships with their providers can be improved. This is not meant to be representative of the overall patient experience, or even that of the Latino patient population as a whole, but it will guide my further considerations of the provider experience in providing for these families in chapter five. These reflections also contribute to my recommendations for potential changes that might be made to make Boston Hospital more culturally competent, as explored in chapter six.

Chapter V

The Provider's Voice

Culturally competent health care has quickly become a popular and politically correct topic of discussion in the medical world, gaining the attention of policy makers, educators, healthcare professionals, and researchers. Despite its popularity, this concept is interpreted to have a variety of different meanings, both in theory and in practice, and assumes a different form in every context. In this chapter, I seek to represent the provider's perspective on cultural competence, a perspective that is often neglected in the literature. I hope to portray the experience of providing for Latino families and the challenges the professionals of Boston Hospital face in providing the high quality care they strive to offer every family. I will do so by first presenting definitions of cultural competence in the words of providers themselves. Next, I will explore themes that embody common challenges to cultural competence. In a third section, I will discuss provider perspectives on caring for Latino families. Finally, I will examine some "best practices" for culturally competent care used by these providers.

Throughout my conversations with the medical staff of Boston Hospital, doctors, residents, nurses, interpreters, and social workers shared their insights on cultural competence, as well as their experiences in working with Latino families in the pediatric in-patient unit as well as the PICU. I asked participants to answer the following question: How do you define cultural competence? The themes embedded in their definitions, examined below, will guide the remainder of the analysis on the provider perspective. While there are many common themes between these definitions, each is also shaped by the unique perspective of the provider and their training background, which I have noted.

How should we define cultural competence?

According to the staff of Boston Hospital, cultural competence is...

“... when you can put yourself in the shoes of the patient and family... and give them information in a way that matches the way they understand what’s going on and can help them to understand what the next step... is. And it’s a form of **respect**... It’s a form of ... **meeting people where they are** and leading them where you want them to go.” – Attending physician

“...taking care of a patient **as a whole**, taking into consideration their **belief systems** and what they think is gonna help, whether or not it’s science-based or it’s evidence-based... trying to incorporate that into their plan of care as much as possible.” – Resident

“... **asking questions** and being **respectful** and mindful of the different beliefs and customs that a family may have ... [I]t’s difficult to do because you can never go in **assuming** you’re gonna know how to treat a certain family.” – Social worker

“... **listening** to different families approaches ... recognizing that our traditional western medicine is such- it’s traditional and it’s western and it doesn’t necessarily factor in other cultures, methodologies, and beliefs. So I think the first thing is just understanding where they’re coming from.” – Resident

“... to understand **attitudes**, not just literal words. Using an interpreter you get the vocabulary... but cultural competence implies a greater understanding of... what **beliefs and attitudes those words are embedded in**...” – Social worker

“... an **open-mindedness** and an awareness of differences... an awareness of my own **limitations** of understanding of other people’s cultures that aren’t my own and then making the best attempts **to understand, to communicate, and to accommodate**.” – Attending physician

As there is no single, accepted definition of cultural competence in the current literature, these definitions can work together to build a more dynamic and practical definition. These definitions are grounded in the lived experience of providers who are faced with issues of language and culture on a daily basis, and therefore, they may prove to be more valuable than an academic definition. Throughout this project, I have realized that a common definition may not be possible or even desirable, as it may act to oversimplify the indefinite complexity of cultural diversity and its impact on the medical

encounter. This definition, which is sought after by researchers, policy makers, and educators, would come at the expense of both patients and providers. Instead of seeking broad definitions and models, I have chosen to focus on the complexities of this particular hospital environment and the perceptions of its main actors. Through this approach, I hope to depict the current state of cultural competence at Boston Hospital, highlighting strengths and areas for growth as expressed by the medical professionals themselves. I am not in any way qualified to evaluate the cultural competence of these professionals or the hospital as a whole, and so I will not try. I will present their individual and shared experiences and attempt to do justice in interpreting them.

Challenges

Acknowledging limitations in a spirit of cultural humility

Even those who specialize in cultural competence will admit that they do not and simply cannot achieve cultural competence, let alone cultural proficiency, in every culture. There are simply *too many* cultures, each with its own richness and depth. Perhaps one can advance to the level of “cultural pre-competency,” as depicted in the continuum of cultural competency on page 14 with a number of cultures, although even this may take a number of years, a great deal of exposure and effort on the providers part. While providers are constantly working towards competence, it is to be expected that they will fall short. This is not due to a lack of effort, but to the nuances of culture and the necessary degree of insider knowledge one must possess. One social worker expressed the sentiments of many when he said, “[W]e have to keep in mind that... I think we strive to be competent. I think you can never know everything about other cultures.” While these professionals continue to strive toward competence, it is important to acknowledge

their own limitations and areas of incompetence. Another social worker spoke of the importance of this when he said, “I think it would be disrespectful to try and pretend that you’re any more familiar than you are. I think being respectful of them and listening carefully, and just being respectful of differences is what I do.”

Provider’s willingness to acknowledge limitations in the realm of cultural competence recalls the attitude of “cultural humility” proposed by Peterson-Iyer (2008).

One attending physician embodied this attitude when she said:

[W]hen I think of a cultural competency... I always feel very conscious of my own limitations because... I’m very humbled by my limitations to understand. So for me, a big part of cultural competency is open-mindedness in trying and communicating, because I know that I’m probably never going to be competent in someone else’s culture...

This sense of humility and recognition of her own limitations are surely a mark of a good doctor who is sensitive to issues of culture and who is actively working to address them through her own attitude and communication style. She explained how she came to see her own limitations through her experience working with Latino families who were especially concerned with fevers, which she referred to as “fever phobia.” These families would often bring their feverish, though otherwise healthy children into the emergency room, expressing a great deal of concern. Initially, she reacted with frustration as these families repeatedly returned with the same concern until one day when she asked a family, “Why does this worry you so much?” She was surprised at their response, which she recounted:

You know we’ve only been in the United States for a couple of years. When I was growing up, fever meant you were going to die and that you were very sick, because I had an uncle who had a fever and had meningitis and couldn’t get antibiotics, and I had a cousin who had a fever and ended up having a very serious bacterial infection and died.

Through this explanation, the doctor gained a new sense of the experiences that created this sense of fear and was able to recognize the roles of culture and poverty in the way these families understood sickness. She described how her perspective changed with this new sense of awareness:

So understanding what fever meant to them...that was very interesting to me and very humbling to me, and I was embarrassed that I had felt this way about these families. Like, of course if they thought their child was going to die for what they brought them into the ER... of course I would do the same thing, and that was just sort of the lens that their experience had taught them.

Understanding this “lens” is at the core of cultural competence, and in order to reach even a limited understanding, one must assume a humble attitude without assumptions.

Assumptions lend themselves to a paternalistic attitude that can threaten the capacity to build relationships as well as the physical health of the patient in some rare instances.

The need to recognize limitations extends to Latino providers as well, as they too cannot be competent in every Latin American culture. One Latino provider acknowledged this in her own approach to care:

I don't want to go in and think, “Well I'm Latino so obviously I know what they're like.” I still like to ask them about... what their family is like, how they grew up, whether they grew up here or did they grow up in their native country, so... it's different because I can just talk to them in Spanish but... I still have to be aware that I don't necessarily know what their culture is.

This comment alludes to the vast diversity found within the umbrella category of “Latino” or “Hispanic,” cultures as well as the danger of excessive generalizations.

Generalizations

The field of cultural competence work is often limited by generalizations. Though generalizations are necessary in some cases, they can easily lead to miscommunications

and a paternalistic approach to care. Practitioners must generalize cultural knowledge to a certain extent order to develop a set of tools for caring for diverse families. They must, however, avoid the danger of over-generalizing to the extent where they do not see what is actually going on in a particular situation because they are dominated by the tools themselves. One physician expressed this dilemma when she said:

I struggle with this, and someone out there has a better answer to this than I do, but how you generalize education about a culture such that you can approach individual families with cultural competency but not over-generalize?

This is an important question that must be approached by medical educators.

Generalizations are especially common when considering cultural competence for the Latino population in the United States. There are twenty countries that make up Latin America, and these countries vary extensively in their cultures, histories, economies and languages. A social worker responded to a question about caring for Latino families by saying, “Hispanic is a pretty big word. We’re not talking about one thing here.” Another provider demonstrated a similar awareness when she observed:

...I know that when you say Latino families, you’re actually talking about a huge geography. You’re talking about multiple continents. You’re talking about multiple countries, and within countries, you’re talking about people with totally different backgrounds... you’re talking about different classes, you’re talking about different education levels, and so when you say “Latino family,” I can’t necessarily generalize...

There simply is no such thing as a “prototypical” Latino family and therefore, generalizations are often useless to providers. With other, more homogenous ethnic groups, a provider may know to avoid looking a patient in the eye, to greet a family in a certain way, or to address the male or family elder during conversation. When caring for

Latino families, however, physicians are unable adopt such a singular approach. This same doctor reflected on how generalizations factor into her means of providing care:

I don't really ask families, "Tell me about your education level. Tell me about which country you're from. Tell me about what your heritage is." I don't ask those questions... I don't actually know what all those things mean and I don't want to assume, you know, "Oh they're Guatemalan and ... therefore, they believe this." ... I assess through my interactions with them where they're coming from... what they understand about what I'm saying through their lens of how they understand illness, and it's through those conversations that I shape how I approach them. So I wouldn't say there's a general way that I approach [Latino families].

Time constraints often prevent physicians from asking the personal questions outlined by this doctor. Without this luxury, and by forgoing risky generalizations, providers are again forced to act in a spirit of cultural humility as they seek an understanding of the patient "lens" or perspective through their interaction. During such interactions, providers come to recognize the interaction of individual, family, and cultural components that blur together within one dynamic. This blurring of personality, family culture, and ethnic culture makes generalizations even less accurate. In some cases, generalized knowledge of Latino cultures can be helpful in informing the provider's approach, however, as this provider notes, each family should be approached in a way that respects their individual qualities. Without this attention to the unique case of each family, generalizations can sow the seeds of discrimination.

Discrimination

Discrimination has been defined as "the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or sex" (Oxford Dictionaries). We are very familiar with this concept in modern American society; so familiar that one might say we are hypersensitive to its existence. In the context of the

immigration debate, overt discrimination against the Latino community has been especially rampant. While discrimination is most visible as malicious acts committed against an individual or group, it may also be manifested in much subtler ways. Discrimination can also occur as an act of omission, unintentionally committed by those with good intentions. This brand of discrimination is a common occurrence in the health care system and contributes to the reduced health outcomes experienced by the Latino community.

Providers amongst the Boston Hospital staff reflected candidly on the occurrence of discrimination in their work environment, as well as their own unintentional discriminatory acts of omission. One provider described the gaps in care for Latino families with low English proficiency:

...[W]ith Latino families... lets say we don't have a translator available, it's a weekend or nighttime, then I think people would say that people often do get less care... when there's a language barrier because people avoid going there [to the patient's room] because they can't really speak to them and they don't understand what they're saying... [T]hat's a huge challenge in health care, that if we don't have appropriate services, then I do think some of the care sometimes gets lost. We don't go in there as often, we don't update them as often, we don't tell them what's going on because we can't communicate with them and you're not gonna get a translator six times during a day. So with Latino families... if they only speak Spanish, we update them in the morning and then they might not get an update unless there's something really significant in their care until the next day.

This physician notes how a lack of necessary resources and services for the Latino community can contribute to lower standards for communication and care. Providers are often forced to make uncomfortable choices with regard to these families because of the language barrier and their own inability to communicate as they would with English-

speaking patients. Another provider commented on her own anxieties in navigating the communication barrier with low English proficiency families:

[I]t would be interesting to know the number of times that I peek in and just... check in on my English-speaking patients versus the number of times I go in and peak in on my non-English-speaking patients, just because I'm also worried that I'm going to cause them anxiety if I go in and can't communicate that I'm just checking in... So I am worried that if I can't express what I'm doing, that I could cause anxiety because... they might interpret me walking in as that I'm horribly worried about their child... I have no way to reassure them.

This anxiety surrounding the doctor-patient communication is often enough to alter the standard of care provided for these families and leave their providers feeling helpless. A communication barrier may persist even when interpreters are available, preventing physicians from dispelling their patient's anxiety, as well as their own. A medical resident expressed her frustrations when she said:

[I]t's hard to get across, sort of... your amount of concern through an interpreter because usually you use specific tones and specific words and specific ways you'd talk to someone who speaks English to tell someone how concerned you are or how not concerned you are and that gets difficult.

Although these aspects of communication may seem basic, they play a fundamental role in the quality of care that a family may receive. Families that do not interact with the medical team frequently and who struggle against communication barriers are more likely to be discharged with remaining questions and concerns about their child's health.

While the medical staff most commonly reported acts of omission, more obvious forms of discrimination rooted in language or cultural barriers may also occur. One nurse reflected on hasty judgments made during the medical encounter:

[S]ometimes nurses may judge incorrectly based on interactions, you know, because you have a miscommunication and they get angry, and you tend to judge them as an angry person when they're not, they're just

frustrated with the language, and knowing what's going on here [at the hospital]. I mean, people who speak English don't know what's going on here [laughing] so I can't even imagine [what it's like] to have it as your second language.

As humans we are constantly forming impressions and judgments, which are often based on emotions. Whether these judgments are well founded or not, they may impact the care the family receives for the remainder of their stay. Such judgments might also manifest themselves as assumptions of non-adherence, as one doctor explained:

[I]t's always on the differential: is this compliance or is this worsening disease?... I'm sure that with the way the medical system works.... There's lots of examples of this, that non-white families are assumed to not be doing what they're supposed to... and that's a class issue also.

This observation notes how this type of discrimination is embedded within the medical system and within society. Providers may more quickly interpret parental behaviors or comments (or lack thereof) exhibited by Latinos or other minorities as "red flags," indicating negligence or abuse.

The nursing perspective is especially valuable in assessing discrimination because nurses interact with their patients on the most intimate level and spend the most time with them. One nurse provided an interesting example of discrimination specific to the Latino population:

Latino families aren't afraid to yell or cry or say "I'm in pain," and I think sometimes I would say this is sort of a cultural thing for them... I think some people [providers] misjudge their pain because they don't give it as much credibility, because they sometimes can be a little more dramatic... And just because they're saying it's [their level of pain is] a 9 [on a scale of 1 to 10] doesn't mean it's not a 9. [It] doesn't mean it's less than someone else who says, "I have a 9."

This nurse draws on generalizations about the Latino population as being more expressive and sometimes dramatic, but she recognizes how this mode of expression may

be “a cultural thing” rather than a cry for attention. She also notes how a provider’s failure to give credibility to a patient’s expression of pain can be dangerous for that patient. If the provider does not respect the patient’s expressions of distress, they may give them inadequate medication, causing them to endure unnecessary pain.

The study of cultural competence was designed to educate providers so that discrimination can be avoided. However, it should be noted that it is possible to begin with good intentions of cultural awareness and then unintentionally practice reverse discrimination. One nurse commented,

You wonder when you’re making too big of a deal out of something. Like everyone’s diverse in their own way. You don’t want to make too big of a deal out of something and end up discriminating in the opposite way, like assuming everyone of a culture is the same.

In the pursuit of cultural competence, it is important that providers recognize the potential for reverse discrimination and avoid it. While providers may seek to treat members of the Latino community with respect for their individual cultures, they must avoid misapplying the same generalizations discussed in the previous section. Even within cultures, each family is its own unique entity, deserving of respect. This must be considered by all of those striving for cultural competence.

The provider-patient relationship: the provider perspective

The perspective of non-Latino providers

Thus far, I have outlined some general themes that inform the provider perspective on cultural competence: an awareness of limitations, generalizations, and discrimination. Now, I will use the reflections of the providers themselves to explore the experience of forming relationships with Latino families. These reflections touch upon

many of the same themes as explored in the previous chapter, including trust and communication.

One medical resident captured the unique experience of caring for a patient from a completely different culture and the sense of inadequacy that many providers may feel:

You get to do the science part of the medical care but you don't get to do the art... because you don't know all the nuances ... you don't know how to express empathy or even put them at ease instead of on edge... And it's a public forum so patients may not be able to say, "You're a male doctor and I'm sixteen years old. You're not allowed to touch me in my culture," when there are eight other people standing around watching this doctor do an abdominal exam.

This "science without the art" description captures how so many subtle elements of care may become lost in the cultural and linguistic divide between patient and provider. This resident felt that she was unable to practice her art as she has been trained to.

Theoretically, training in cultural competence should equip providers with means of adapting this art to different cross-cultural situations, but this is a formidable task. This resident's observation is also valuable in that it notes how the cultural preferences of a patient often go unspoken in the medical encounter, especially during medical rounds when patients may feel uncomfortable expressing such preferences. A doctor or nurse cannot adapt her art to the particular culture of a patient when aspects of that culture are never communicated.

Many providers reflected on how their own ability (or inability) to communicate impacts their interactions and relationships with Latino families. Good communication is the means through which providers can practice both science and art. One doctor reflected on the importance of communication to her role:

You know for me... communication is ... the cornerstone of, of medicine in general... I could do everything completely right and pick the exact

right antibiotic and diagnose something perfectly and order all the tests exactly right but if I can't communicate my process to the family... when that's limited I feel anxious because I feel like I can't do my job.

Communicating with Spanish-speaking families is especially precarious because many Americans know some Spanish, whether words or phrases, although most providers do not know enough Spanish to adequately communicate with their patients. Despite this, providers may choose to forgo the use of an interpreter and try to communicate with low-English proficiency patients either in Spanish or in English. One nurse recognized the danger in this:

B]ecause a lot of Spanish is a lot like English...sometimes you think that you're having a valid conversation and then you realize after the fact that you weren't... talking about the same thing. Because words kindof sound the same ... like you think ... it seems like everything's going fine and then afterwards you realize that they didn't understand what you were saying.

This type of mistake can quickly lead to misunderstandings with potential consequences for the child's care, and so, it is important to use an interpreter whenever possible.

Communication becomes even more complicated with the use of complex medical language. Even if a Spanish-speaking patient is able to communicate conversationally in English, they may not understand medical terminology in English. Many physicians that I spoke to were aware of the importance of the use of interpreters, although they struggled to coordinate with them, a topic I will discuss in the final chapter of this work.

Beyond the practical implications of poor communication, doctors were very aware of its impact on their ability to create strong relationships with Latino families. One doctor discussed the crucial role of communication in building trust in these relationships:

...I feel like some of that trust is harder to establish when you don't have... the casual communication, the ability to just go in and easily check in, walk by the door a couple times a day, peak your head in. And I know I've heard nurses express the same thing. That bedside minute-to-minute communication is lost and that's such an important part of the relationship that... caregivers have with patients in the hospital.

This observation echoes the sentiments of patients who sense the same difficulty in building trust in their caregiver, which comes through such minute-to-minute communication. The use of an interpreter improves communication between the and patient and provider, but it is unclear whether it facilitates trust building. This same doctor also reflected on her experiences using an interpreter:

You know, that sort of casual ... intimacy that you can have is lost when it's a prescribed time and you're relying on another individual to convey your tone and your meaning... there's certain things I need to communicate and I need to use this time wisely and it's a different sort of way of structuring physician-patient communication. I think we try our best to keep the same values... but... my observational experience is that it doesn't work as well... I feel less comfortable that the things and communication that are so important to me, which really are tone, and ... I just feel like I lose that through interpreters...

In this encounter, any sense of intimacy is sacrificed at the expense of communication and, as this doctor expresses, her values as a practitioner may be compromised. Others also expressed this tension during their interviews, and were aware of how this affected their ability to truly "connect" with their patients. The experiences of Latino providers reflect a very different side of the provider-patient interaction. One non-Latino resident observed the difference in relationship building between a Spanish-speaking colleague and a particularly challenging Latino family as compared to her own experience in communicating with that same family:

[T]here had been another resident two years prior who spoke Spanish very well and knew the family and he didn't really have the same kinds of problems with the family that we did. But when he left there was this

vacuum and none of us was able to step into that empathetic role and that doctor role at the same time.

The following section will portray the perspective of Latino providers through their own words, exploring how they fill the “vacuum” that non-Latino providers often cannot.

The perspective of Latino providers

I was able to speak with three Latino members of the medical team based in the in-patient units of Boston Hospital, as well as two Latino interpreters. These providers represent a variety of nationalities from South and Central America, as well as Puerto Rico. While some were born in the United States, others were born in Latin America and lived there for varying amounts of time. Together, they represent a diverse cross-section of Latino health care providers. The members of the medical team emphasized how central their own ethnic identity can be in their ability to form relationships with Latino families. Even if they do not share the same nationality, their language concordance offers an advantage that, in the words of one provider, “automatically makes things a hundred times better.” One resident commented that, “[W]ith most of them I have a very close relationship that I ... can form just by the fact that I am Latino as well. It’s like instant bonding for them and... sometimes it makes them feel at ease, like ‘Ahhh [sighing] okay, you’re Latino.’” This visible relief and “instant bonding” sets a tone that is completely distinct from that noted by non-Latino providers. This bond is a powerful experience for providers as well. In an interview with one provider, she expressed the link between this bond and her own motivation to work with the Latino population:

[B]eing Latino I feel like I’m doing something for, you know, my people and... I have family members, like my grandmother doesn’t speak English so... it feels good to be able to provide services to people who are in this stressful situation here... I love that I can go in and once they know I speak Spanish, it’s a relief to them.

As this provider notes, this ease of communication makes a significant difference in such a stressful environment. A Latino provider may create a “safe space” for families who feel insecure in a bewildering environment and who are struggling with the stress of caring for a sick child.

One resident provided a telling example of how having a Latino provider may have made a difference for one family. The resident described the case of a teenage girl who was admitted as an inpatient, depressed and overweight, with a Spanish-speaking mother. One day after rounds, the mother approached the Spanish-speaking resident and confided in her. The resident’s account is as follows:

[T]he mother was like, ‘You know, I’m really concerned about her.’ And then she comes over and she was like, ‘You know, we’ve both been abused by her father...’ and it was kind of this hush, hush, like if she told me then they’d be ok, [and] she didn’t have to divulge to the whole group...

The resident continued to describe her interaction with the teenage daughter:

I think she felt comfortable talking to me. But we were speaking in English. It’s not like her and I were speaking in Spanish, but I think that she felt I was able to speak Spanish with her mother. I somehow, in some way, shape or form, cared the extra bit to be involved a little more, um, and so I think I think she was open to having psych [i.e. a mental health specialist] see her in the morning. So in theory maybe it helped [that I was available]. Maybe I didn’t help at all. Maybe I made matters worse, to be honest. But in terms of the communication, the communication was broadened for sure.

Although this provider was not certain that language was the deciding factor in the daughter’s agreement to a psych consult, we cannot be sure if this same outcome would have resulted had she not been involved in this case. It is possible that the mother’s decision to divulge the abuse to her in particular was based on their language concordance but, again, we cannot be sure. However, it should be noted that this issue is

sensitive enough that it might be more difficult to discuss through a third party interpreter. Despite the fact that the end result of this interaction is unknown and, as this provider notes, her involvement might have “made matters worse” in some way that she does not specify, this additional information allowed the provider’s to understand the whole story behind this patient’s condition. It also opened the doors for intervention on the behalf of the girl and her mother.

Beyond language concordance, Latino providers and Latino patients may have access to shared cultural knowledge, or cultural health capital, that can alter their interactions and relationships. One resident explained an intake interview with a family involving the use of a folk remedy and the nuances of such knowledge in his care for them:

[S]o it’s like all these things... they don’t make sense to anybody else but they make sense to me... I had a baby that came and had a little ... string on his forehead. So when Latino babies have hiccups...[laughing] you put some saliva on their forehead and you stick a piece of string on their forehead and that makes the hiccups go away. And so I didn’t mention it at all, I did my whole exam and I left the string... My supervising doctor comes in and he’s like “Oh you have a string [on your head]!” And he pulled it off [laughing] and the mom’s face was like “OOOH, my God! The hiccups!” And I jokingly said to her [in dramatic fashion] “Oh my God! The hiccups are gonna come back!” and I said it in Spanish, not to undermine my supervising doctor’s authority, but after they left, we got another piece of string and we put it back on. You know it’s [a practice like this is] not gonna hurt.

This case is particularly instructive because it shows the subtle ways in which culture informs the provider-patient interaction. Because the doctor was familiar with this folk remedy from his own childhood, he was able to handle the situation from an “insider” perspective. He did not call unnecessary attention to the string, nor did he swipe it away as his supervisor did. He demonstrated the sort of cultural competence that is often only

available to those who are from the same culture, as he recognized the situation and deftly resolved it by reapplying the string after its removal. This action, paired with his sense of humor, likely made the mother feel comfortable in a way that the supervising physician had not. From a cultural competence perspective, we can see how such “competence” is often embodied in everyday interactions that may initially seem insignificant but often make all the difference.

These indications of shared cultural knowledge may be indicative of a deeper cultural “common ground” between the family and their caregiver. This same resident reflected that, “[I]t’s like a bonding experience because we can share some cultural things, like... joking comes easier and... humor comes easier... slang from back home... I find that that makes them feel at ease, especially the parents...” Slang and humor may serve as indications of greater commonalities for the families. He continues:

I think that because there’s that common ground, there’s a lot more trust. Because they believe that I understand where they’re coming from, that I share the same cultural background... they assume that because we’re Latin that we have the same values, the same set of beliefs, which may or may not be true, but I think that... it allows them to trust me more easily.

As this resident acknowledges, patients assumptions may not be completely correct and they may not necessarily share a common “Latin” set of values or beliefs. However, this sense of a basic commonality is correlated with trust and, in turn, facilitates openness during the provider-patient interaction. This can have concrete implications for patient outcomes. For example, one provider observed, “[I]t’s really interesting to me how, as soon as they know that I speak Spanish they’re a lot quicker to ask all those questions they’ve been wanting to ask the doctors.” The literature posits that Latino families may be more engaged and interactive when working with other Latino providers, and often

ask more questions than they otherwise would. For instance, Seijo et al. concluded that Hispanic patients treated by bilingual, Spanish-speaking physicians had better recall and asked more questions than counterparts cared for by monolingual English-speaking physicians. These authors used their data to support the hypothesis that, “when physician and patient communicate in the same language and have similar cultures, the patient understands the information given by the physician better and participates more actively in the interaction” (1991). This small difference could have positive implications for parental understanding and adherence.

The “Culture of Biomedicine”

An additional facet of the provider experience, regardless of the provider’s ethnic background, is the medical culture in which the provider was trained. Arthur Kleinman refers to this as the “culture of biomedicine.” Earlier in this chapter, a resident noted, “traditional western medicine is such- it’s traditional and it’s western and it doesn’t necessarily factor in other cultures, methodologies, and beliefs.” This observation points to the fact that the medical establishment itself has its own particular culture, based in the tradition of Western thinking. This means that during the provider-patient interaction, there may be up to three cultures at play: the culture of the patient, the culture of the provider as related to his or her ethnicity, religion, etc., and the culture of the provider as a member of the medical establishment. This adds a degree of complexity to the interaction between providers and patients for which there exists no interpreter. As discussed earlier, individuals may not recognize their culture as a “culture,” but rather as the norm. This applies to practitioners trained in the culture of biomedicine, as well.

Although providers may not recognize this “culture of biomedicine” by name, a few of them alluded to it during our conversations. One physician reflected on her own beliefs without solicitation:

I don't have any explicitly cultural beliefs about fever and pneumonia, so it... doesn't occur to me... to think... because it's not that big of a deal to me... that's my default... Everyone's default, is their own experience and... I just don't have a lot of strong cultural beliefs or religious beliefs about illness treatment. **I believe in medicine.** Lots of doctors believe in medicine... I mean I think it's really difficult to practice Western medicine and not believe in Western medicine... [T]here's a belief there, you know, there's... medicines, and treatments, and being in the hospital when you need to be makes you better and that's a good thing.

This physician proved to be especially self-aware and able to comment on her approach to the cross-cultural medical encounter, as well as to reflect candidly on her belief in the biomedical model. I would argue that many health care professionals ascribe to this same belief system based around the effectiveness of traditional, western medicine as their “default,” although few would have the ability to articulate the role of this belief in their interactions with patients.

I asked this same physician if, in her opinion, a “culture of biomedicine” exists.

Her comments shed light on important implications for the medical encounter:

[I]t's an interesting thing to think about that if there is this sort of biomedical culture... I assume a patient understands that culture's perspective... I assume that when a patient comes to seek care, they're seeking care from a model that they understand and that by coming into this system, they're accepting that sort of biomedical perspective, you know? Well that's what they came for, right? And then you wonder if that works both ways. Like does the family assume that I have more understanding of their culture as well? Just because it makes so much sense to them, like how the biomedical culture makes so much sense to me because I live it every day. I don't know... I never ask... I probably should.

This assumption of mutual understanding is a natural inclination on the part of both patient and provider, although it can easily result in a misunderstanding. In many cases, Latino families are not necessarily seeking care from a model that they understand. I would argue that the majority of Americans do not necessarily understand the medical system or the nuances of a biomedical model of disease. However, immigrants transposed from a different health care system may experience this lack of understanding to a greater degree. This provider acknowledges how she should address this cultural mismatch in the medical encounter by asking the patients to explain their own expectations. When I asked another practitioner the same question, he also commented on the importance of asking questions:

...I was... trained in biomedicine... but you do need to take into consideration all these other cultural things... They're going to do what their grandma said or what the elder or ... [whoever the] leader in their specific culture is, and I think one of the big things you have to do is just investigate. Like ask, "What do you think we should do?" or "What other things have you tried?"

These questions acknowledge that the provider's biomedical explanatory model for the illness may not necessarily correspond with the patient's own explanatory model or "illness narrative," as informed by their culture and experiences. His awareness of the importance of "other cultural things" indicates that his biomedical training has not completely blinded him to the many interacting cultures within the medical encounter. In order to provide high quality, culturally competent care, providers must explore the patient's model and work to accommodate it as much as possible. This requires both awareness and sensitivity, as demonstrated by this provider. Such sensitivity may come from the provider's own experiences as a patient in the healthcare system. One provider reflected on her own experience, saying:

... [A] lot of what we do in medicine... it can be very dogmatic and less nuanced and I think having now had the experience of not being the practitioner who's part of that dogmatic culture and more the recipient, and seeing some of the nuances and the way you feel, it's much less black and white than I realized.

This comment reveals a new sense of empathy that this provider felt for the patient after being the recipient of care herself. She also demonstrates an awareness of the ways in which the medical culture may fail to capture the complexity of the patient experience. This awareness has the potential to shape the way this physician relates to her patients and the compassion that she shows them, which can truly make a difference in their experience at Boston Hospital.

Best Practices

Attitude

The families interviewed for this project emphasized the importance of their provider's attitude in their ability to build a relationship with them, as well as in their child's overall in-patient experience. Providers were also aware of the importance of their own attitude and strive to maintain a positive attitude when working with patients, despite the challenges they may face. One provider spoke of her own attitude, saying, "[C]uriosity and open-mindedness is such a big part of it because... you're obviously a better physician when families trust you..." There seems to be a strong correlation between attitude and trust. After all, patients are rarely able to evaluate a provider's technical skills, although they can easily gauge their attitude. Providers that approach patients of diverse cultural backgrounds from a place of open-mindedness may be able to connect with families more easily, while avoiding miscommunication and inadvertent discrimination.

Taking cues

Many providers spoke about the importance of “reading” their patients for cues present in their communication, facial expressions, or body language. In order to respond to these cues in a spirit of cultural competence, the provider must be sensitive to them, and adapt their style of care accordingly. One resident commented on his experience with non-verbal communication:

[Y]ou’re more aware of the nonverbal cues that your patients give you, especially when it’s a culture that you’re not really familiar with. It’s something that you have to be very aware [of] when you walk in the room and you have to be aware of the interactions and how people approach you and that sort of thing... that sort of thing you pick up as you go and you just go with it. It’s very different with every patient interaction”

These cues are unique to each family and each situation. Some may be related to the individual’s culture or their individual personality, although it is often difficult to differentiate. For example, a patient may come from a culture in which direct eye contact is offensive, or he or she may simply be shy. Regardless, the provider must read these cues as best he or she can and react to them accordingly. Providers commented on how these cues are increasingly difficult to read when a language barrier exists, as they are unable to read conversational cues and are forced to rely more heavily on guesswork.

The nurses that I spoke with provided unique insights into the importance of reading cues because they interact with patients the most frequently. One nurse expressed her *tabula rasa* approach to nursing care:

I think the biggest thing is not to assume when it comes to people that you’re not familiar with culturally. You just need to go in with a blank slate and take cues from your patient because if you go in assuming one thing and that’s not the way that they live their lives then...

As discussed earlier in this chapter, generalizations and assumptions can lead to medical errors and inadvertent discrimination. This approach is one strategy that providers can use to avoid such negative consequences. Another nurse explained her own similar approach in which she constantly adapts her care to the cues that her patients display:

[Y]ou learn about disease pathology, but your main thing is: figure out what they need and then do that, whether it's by your personality or explanations that they need... that's always your focus... you're constantly taking cues from them, what they're liking from what you do and what they're not liking. And physicians don't focus on that as much.

This nurse practices such flexibility in her care that she personalizes everything to her patient's preferences, from her explanations to the personality she displays during the interaction. She articulates how her response to patient needs ranks above the importance of disease pathology, which differentiates her style of care from that of physicians. This difference may be related to the philosophy of nursing care, as compared to the philosophy of physicians, and may reflect a different facet of the culture of biomedicine. In any case, the ability to read and respond to cues is an important step towards cultural competence. As physicians will never be able to consider themselves fully proficient in another's culture, they can learn more about their patient's cultures through the subtleties of the medical encounter.

Asking questions

The provider definitions of cultural competence that appeared at the outset of this chapter often specified that asking questions is an important best practice for cultural competence. In a similar vein, one nurse simply stated that, in order to discern what is “cultural” and what is rooted in an individual's personality, “[Y]ou just have to ask the

right questions, I guess.” Unfortunately, providers often fail to ask important questions, which thus go unanswered. One social worker recognized this:

...[S]ometimes we’re telling families... “You need to do X, Y, and Z. You need to do this differently” and sometimes we forget to ask if that is problematic at all for their own customs. So it’s hard and you have to keep remembering and I think sometimes... we don’t... it’s so just not in our world that we wouldn’t even think to ask a question like that...

During a cross-cultural interaction, it is important to pause and consider whether there are any unanswered questions. This may involve assessing patient cues, as mentioned previously. Unfortunately, many questions relating to patient culture and preferences are only raised if the provider-patient interaction is not going as planned. In such a situation, one resident described,

I usually step back and go “Ok, what’s not going right here?” And sometimes... you have to ask, like “I’m sorry, is there something that I can do to make you feel more comfortable? Do you want me to step out? Do you want the medical student to step out? ... [D]o you prefer the medical student to be a female?” And you just have to play it by ear.

In a way, such questioning can serve as a form of detective work, as the resident uses these direct questions to identify the root of the problem and correct it.

Questions may be used differently during the medical interview, as the doctor or nurse gets to know the family and explores the parent’s explanatory model of their child’s illness. One physician explained her strategy as such:

[S]ometimes we’re very prescriptive when we talk with families and if you want to be truly culturally competent you need to ask open-ended questions and really give patients the opportunity to give you their explanatory model of why they’re child is sick, and the way care is set up here we don’t often give parents and patients that opportunity to explain their model really how they see it...

This physician notes how the medical system and the traditional medical interview do not necessarily make room for this explanatory model which may only come out when the

interviewer asks questions and takes time to *listen*. Another doctor shared an example of this in her own experience, in which she asked questions in order to learn about a specific cultural practice unique to a Latino subgroup that she once worked with. The families wore jewelry, either made out of amber or coral, which were passed down through their families to their young children. By asking questions she discovered that the jewelry was intended as a protective measure against disease. She explained:

[I]t really helped me to understand where patients were coming from. I just started asking a lot of questions... And I just found that families were so receptive to me asking... like, "I've noticed a lot of my patients wearing a bracelet that's similar to yours. What does that mean to you?"

This case demonstrates how questions can serve to bridge the gap in cross-cultural interactions. Questions such as this one can be a respectful way of showing interest in a patient's culture, while also providing useful information on how best to care for their families. In many cases, patients respond favorably when a provider shows interest in their culture, as it may be an indication of their provider's care and attention.

Addressing parental concerns: meeting them where they are

In order to work with a family toward the health of their child, a provider must first recognize "where they are," or where the family stands in terms of their culture, health literacy, emotional ability to cope with their child's illness, etc. One physician described how she gets a sense of a family's situation and incorporates it into her care plan:

I think the way I approach my interaction with families is figuring out where they are, meeting them where they are, and explaining to them what they need to know in order to take care of their child... Everybody has their own thing that they bring to that interaction and being culturally competent is one example of how you meet someone where they are and take them where you want them to go.

This style of care is sensitive to the family's needs and works with parents in order to care for them in a way they will be comfortable with. In order to reach this point, however, providers must first respond to the specific concerns that parents may have regarding their child's care. Another physician emphasized the importance of sensitivity and responsiveness to parental concerns when she said:

... [Providers should] always [acknowledge] their fears and anxiety because every parent when they come to the hospital with their child has some fears... I think the biggest thing is just always acknowledging what their concerns are and addressing them, and not just saying, "Oh, we're not worried about that."

Whether or not the concerns of the parent are aligned with the concerns of the provider, the provider should be careful not to dismiss them in this way. Instead, they should ask the parents to explain their concerns as well as the reasoning behind them, which allows them to adjust their care plan accordingly. One provider noted the importance of this approach in building patient trust:

I try to listen to families, find out what their concerns are, and then frame whatever guidance I'm going to give based on their concerns. And I think that's a way to develop trust, and I think always asking, "How do you feel like your child is doing?"

When parents are asked to articulate their concerns and opinions they begin to feel like a partner in their child's care. The family-centered style of care implemented at Boston Hospital aims to involve the parents as partners much as possible, empowering them to become advocates with a voice in the decision-making process.

Empowerment

A final "best practice" that providers considered important to cultural competence was empowerment of patients from other cultures. Social workers in particular are trained

to work with their clients toward the goal of empowerment. One social worker commented on his view of his own role in this process:

...I try to be respectful if you're trying to push an American idea on somebody with a different culture and you sense that some of their resistance to it is coming from that difference, to not try and run over that idea with your own idea of what should happen... You try to be an advocate and align yourself with the family... [In social work] it's always about empowering people to be able to have some control over their own life and express their point of view.

This observation demonstrates the importance of respect for different ideas about care, especially in cases of conflict. In order to be culturally competent, the medical team must consider the patient or parent's level of understanding and their desires for the direction that care will take rather than "running them over" in a paternalistic manner. Social workers as well as doctors, residents, and nurses can all have a role in empowering patients through support and advocacy.

Empowerment, however, can be a complex and difficult pursuit. One physician explained her struggle with the task of empowering the Latino population in particular:

Part of family-centered care is helping families understand... helping them through access to knowledge and understanding [how] to be a better advocate for their child... [It's] very easy for me to explain and empower to a culture that I understand, but I don't know how to empower... or how a Latino family wants to be empowered, or if they want to be empowered, or what their understanding of empowerment is when it comes to being in the health care system.

This perspective is especially interesting, as she explains advocacy in terms of access to knowledge. This can be interpreted according to Shim's concept of cultural health capital, in which knowledge regarding medicine or the medical system itself can be used as a power resource. In this case, the physician and the Latino family she cares for have access to different forms of cultural health capital. The knowledge that this physician

refers to is institutionalized knowledge within the medical establishment that Latino families and those of other minority groups may struggle to access. While empowerment might involve sharing of knowledge with these families, this physician is uncertain of how to do so. She is unable to connect with and empower Latino families in the way that she might empower white, English-speaking families who share a common ground of cultural capital. Although there is no clear solution to this problem, the use of interpreters or “cultural brokers” could serve as a first step.

Throughout this chapter, I have attempted to portray the experiences of the pediatric in-patient medical staff of Boston Hospital in providing care for Latino families. I have explored their own definitions of cultural competence as well as their insights on the challenges that they face in their efforts to become more culturally competent. Lastly, I outlined five practices that the providers themselves find important. It should be noted that these “best practices” are not exclusive to cross-cultural medical encounters with Latino families, but are positive strategies for working with any family, whether they are members of a minority population or not. As a whole, this chapter, along with the reflections of the patients themselves, will inform the final chapter of this work, which presents my own recommendations for changes that, if implemented, could make Boston Hospital a more culturally welcoming environment for Latino families and those of other cultures.

Chapter VI

A Vision for Change

Throughout this project I have realized that there is no single definition of cultural competence, nor should there be. Cultural competence is a dynamic and context-dependent ideal that health care professionals should continue to acknowledge and strive for, despite the limitations they will inevitably face. In addition, I have realized that it is impractical to seek a standardized model for providing high quality care to Latino families, a population known for its rich diversity and varied needs. At the outset of this project I thought I might use reflections of providers and families to piece together some sort of model, though I soon realized this would not be possible or even helpful. Instead, the staff of Boston Hospital have taught me that knowledge of a patient's culture must be balanced with the "culture of the family" and the needs of the individual in each unique circumstance. As a result, I am not able to systematically assess the cultural competence of the pediatric inpatient units of Boston Hospital, nor am I able to present a concrete plan for improvement. Instead, I will draw upon the observations of medical staff to outline a broad vision of changes that would make Boston Hospital a more welcoming environment for culturally diverse patients. These changes are not meant to be exhaustive, but rather a first step towards providing culturally competent care for the Latino population as well as all other minority groups.

While these recommendations are limited, they should be rooted in a deeper pedagogical shift in the approach to cultural competence. The current focus emphasizes the importance of learning the traditions, beliefs, and preferences of a particular culture. One nurse summarized her experience with this style of instruction:

[T]hey make us do a mandatory ed [education] every year that's called cultural something... and it's a PowerPoint presentation where they just go through... you know, some cultures don't like you to look them in the eyes. Don't pat Asian kids on the head. Like it's just those one-liner, almost like stereotypical things...

As discussed earlier, a focus on generalizations can cause dangerous misunderstandings and inadvertent discrimination. Educators and providers should abandon an approach to cultural competence based on generalizations in which they may presume to know more about a culture than they actually do, and instead adopt a broad, skills-based approach. If providers are educated according to the qualities and best practices discussed in the previous chapters, they will be better prepared to adapt to families of many different cultures, regardless of whether they are versed in their particular characteristics or not.

One resident insightfully articulated this shift in focus:

I think historically, people felt that cultural competence was actually knowing how to approach a specific culture or how to approach... the particular unique qualities of a group of people... But I think a more appropriate way of assessing cultural competency is teaching people how to approach these cultures... so rather than content-based [education, it should] be skills-based because I think that's more widely applicable... so I think I would rather teach or learn a skill set on how to approach and how to interview appropriately and how to talk appropriately...

Although content-based education should not be discarded altogether, this shift from simplified content to widely applicable skills can allow providers to adopt a more open-minded attitude toward the cross-cultural encounter. Such a shift will, in turn, improve the provider's ability to respond to culturally diverse families, whether they are from Boston, Bolivia, or Bhutan.

Underscoring the importance of culture

My first practical recommendation is that leaders at Boston Hospital emphasize the importance of culture in everyday interactions with families. These hospital leaders

should encourage providers to consider the role of culture in the patient's illness experience from the intake interview until they are discharged. All providers, whether attending physicians, residents, nurses, or nursing students, should come to acknowledge this element when approaching a family. As a teaching hospital, Boston Hospital has a special role in forming a new generation of culturally competent healthcare professionals.

While most research participants were aware of the term "cultural competency" and were able to describe its importance within medicine, it was unclear whether cultural competence had become integrated into their approach to providing care. One nurse laughed as she described the current approach to culture in the intake questionnaire used for all patients in the in-patient unit. She explained, "[W]hen we meet a family we have all these questions that we go through and... what cracks me up is the way that the we address culture is ... all we say is... 'Culture or religious beliefs? Yes or no?'... That's not an appropriate cultural assessment." It is clear that this "yes or no" question could not possibly capture the complexity of a family's cultural or religious beliefs, many of which may be relevant to their health care needs. Rather, this question glosses over the issue of culture as a small part of a lengthy questionnaire. This same nurse noted that, in her opinion, culture is not *always* relevant to the medical encounter. Instead, she observed, "I think you have to really get to the point of what of all their culture will be relevant to this... encounter with us." While culture may not be relevant to every situation, it is impossible to know the role that culture may play without recognizing its influence in many cases and without asking insightful, open-ended questions.

One physician expressed a related concern when she described how, in her experience, the cultural dimension of care is often neglected until a problem presents itself. She described how cultural competence may be a part of a “plan B” for families:

I feel like oftentimes the cultural competency “red flag,” so to speak, gets raised for me after a family is not compliant, or seems resistant to whatever treatment plan or recommended course of action that you [have suggested]... it’s like you have to fail once to then remember to add in the layer of [culture]... [I might need] to ask the question, “So why might this family not be comfortable with this?” or “Why isn’t this family comfortable stopping antibiotics?” and then... is this about this individual family? Is this about this individual’s family’s past experiences? Is it about this family’s culture?

This candid response reveals a common reality for physicians. Cultural competence is too often considered a response that one makes only when a “red flag” appears, rather than an integrated component in the approach to care that many providers take. While the questions that this physician considered after an initial failure are insightful means to understanding the family’s perspective, these questions should be raised before miscommunications and issues of non-adherence arise. This outcome may be achieved, in part, through medical education and training.

Education

When I asked providers, “What changes should be made at Boston Hospital to better serve families with specific cultural and linguistic needs in a more sensitive way?” the majority mentioned the need for improved cultural competence education. Of these respondents, most echoed the sentiments of one resident who said, “I think that videos or PowerPoints are useless. I could learn zero from them as a student and as residents we probably learn zero from them.” A social worker added that in his experience classroom learning could only point healthcare providers in the right direction, though it is simply

insufficient by itself. Some offered the opinion that the current approach to continuing medical education offered at the hospital is somewhat dry and, in their opinion, less than useful. Another resident provided a candid perspective on the cultural competency lecture series implemented in years past:

My first year some of the lectures ... were kindof offensive in the sense that I felt that they weren't a realistic projection of what actually goes on in medicine right now... the models ... weren't applicable anymore and it felt like it was an hour long session where [we were told] how we are bad doctors when a lot of the specific practices... mentioned we don't do anymore, you know? So it just felt like it was an hour of ... emotional abuse, but not necessarily... practical...

While lectures on cultural competency have value as an introduction to the topic and will always be central to the medical education model, I will use provider comments to suggest complimentary approaches that emphasize hands-on experience, making lecture material more practical and engaging. A few respondents remarked how, unfortunately, it is often largely up to the individual provider to investigate issues of culture and improve their own competency. It is my hope that this reality can be transformed through complimentary approaches to cultural education.

Many respondents expressed how they learned the most about cultural competence through experiential learning. One physician told me, “[T]he experiences ... that have been the most valuable from a... cultural competency perspective, they’ve all been patient-based in something that I don’t think could be captured particularly well in a lecture.” A lecture is simply not dynamic enough to capture the nuances of cross-cultural encounters, the frustration that providers may face when presented with a cultural or linguistic communication barrier, and the revelatory experience of overcoming such a barrier. One resident reflected on a personal learning experience in which he made a

mistake based in his own cultural incompetence or blindness. He expressed the ways in which personal experiences and “teachable moments” have impacted his own practices more profoundly than formal education:

[T]he real life practice is what’s gonna be important. Like I got all those lectures with... with some middle eastern women you don’t look them in the eye, blah blah blah, and what did I do when I went in [to the patient’s room]? I looked them in the eye. And I know all of these things. I memorized them, but until you see it... never again will I outstretch my hand unless they outstretch it first, you know? So until you live it and you deal with it in person, that’s when you will truly learn.

This encounter, marked by the discomfort of a cultural miscommunication and an unintentional breach of respect, left an impression on this resident that inspired him to be more culturally competent in the future. This reflection highlights how lectures and “standardized” cultural knowledge only become real when grounded in experience. This holds implications for education and for the role of instructors in residency programs. Attending physicians must take a leadership role in exposing residents to such cross-cultural encounters and helping them to navigate the encounter in a sensitive manner. In addition, training should incorporate as many practical elements as possible. For example, incorporating case studies and simulations may be useful ways to connect lecture material to the care giving experience itself.

Understanding culture through a community context

While culture is manifested differently in the experience of each individual family, culture is embedded in the context of one’s community. In order to understand the experience of a family from a cultural perspective, it is helpful to look to the family’s community for insights. The resident quoted in the previous section provided some

additional reflections on how cultural education might be improved through making use of community resources:

I think a better way would be... bringing somebody in and talking about their experience as a patient, or a volunteer from that community and having interview scenarios. In the same way as we train as doctors with standardized patients, we could do that with different standardized patients of different cultures.

Although this standardized approach may be susceptible to the downfalls of over-generalization, it would be advantageous to use community resources to interact directly with former patients or community members. This would allow providers to hear an individual's story and to reflect on it from a cultural perspective. They may ask unanswered questions to gain insights into the particular culture represented. The experience of going through interview scenarios with such an individual could also provide valuable practice that these providers may not otherwise experience, preparing them for sensitive situations that may arise in the future.

One physician described the challenges she faces in caring for the Latino population, highlighting in particular her own sense of disconnect from the Latino communities in the Boston area.

...I don't know where they come from and they're from such a diverse background, and I don't know what it's like where they're from... When did they come here? ... What country are they coming from? What's that country like? I know a lot of our patients come from the Lawrence area... and they have a huge Dominican population, a lot of Spanish-speaking patients...

While the answers to each of these questions vary considerably by family, this physician expressed a deeper uneasiness with her own lack of cultural and community-based knowledge. She proposed an interesting means to address this problem within the resident education program that she is involved in, in which a class would speak with a

representative from a community like Lawrence. This would allow the residents to get a sense of where their patients are from, the demographics of the area, the general beliefs and customs of these patients, available services, etc. She also proposed that a class might visit the community under the guidance of a local social worker so the residents might get a sense of the living situations and barriers to care that Latino families in that area face. This is especially important because, in the perspective of the provider,

[T]hen we can really understand and relate... because especially for us when we send them home from the hospital, we have to understand where we're sending them to know they'll be safe there, that they'll be able to give the antibiotics, they'll be able to see their doctor, and if patients don't have a car, you know, there's only one person who speaks English in the home, what are we gonna do if they can't fill their prescription? What would they do? ... [W]ould they be able to get help for that or would they just not get the drugs?

As this provider notes, knowledge of the community can make a significant difference in the provider-patient interaction and the health outcomes of the child. If a provider has knowledge of community resources, they might be able to tailor their care plan to make use of these resources and work around existing barriers. If strong partnerships can be established between these communities and the hospital, such knowledge can be shared more freely and cultural competence will be improved as a result.

Interpreter Services

Interpreter services can act as a powerful link between patients, their communities, and the medical team, serving as cultural brokers in the information exchange mentioned previously. I had the opportunity to shadow interpreters on multiple occasions and interviewed three Spanish-speaking interpreters during this project. While shadowing, it quickly became clear that these members of the medical team are stretched thin in terms of their caseloads. They are constantly moving between the wings of the

hospital and, much to their chagrin, they never seem to have enough time with each patient. Interpreters are important members of the medical community and proponents of culturally competent care, although they often go unappreciated. Therefore, cooperation with and utilization of interpreter services is a logical target for improved cultural competence.

One physician identified improvements in linguistic competence as “the low-hanging fruit of the way we can start being as culturally competent as possible.” She explained:

“...[T]o me language is one of the most easily identified and easily actionable ways of showing respect to another culture... I think that’s where you have to start because that’s the fundamental piece of it when it comes to direct patient care and... language is such a fundamentally important thing for patient safety, for communication, but also for patient respect and satisfaction...”

This provider expressed her awareness of resource challenges faced by the hospital, yet she still advocated for an increased investment in interpreter services in light of the particularly diverse patient population at Boston Hospital. This crucial investment would allow the hospital to hire a greater number of interpreters for all languages. Most Spanish speaking interpreters currently work on a part-time basis. Such an investment would allow for a full-time interpreter to work at the hospital, ensuring that current gaps could be covered. With a more extensive staff, services might be made available during nights and weekends to support families throughout their stay. Investments might also expand the budget for new interpreting technology, such as improving interpreter telephones and upgrading existing phones to video monitors, allowing for face-to-face communication.

Another problem that must be addressed is the utilization of current interpreter services. When I asked many providers to describe their experiences working with

interpreter services, many commented that interpreters (including Spanish speaking interpreters) are rarely used on the pediatric in-patient units. The interpreter phone is more commonly used for daily needs and interpreters are primarily called in for family meetings. Interpreters verified this fact, remarking that they are rarely called to interpret in these units. No one, however, could explain this lack of use. This is somewhat disconcerting, as using in-person interpreters is not only more effective, but also more comforting for families.

From a nursing perspective, it is especially challenging to work with low English proficiency families because they are constantly negotiating the language barrier. One nurse explained her struggle to work in cooperation with interpreter services:

I've found interpreter services, like never available... [Interpreters are] good for when you want to have a talk, but all of these things come up on the fly. Like when I had that urine problem, it wasn't like I could call interpreter services and say, it's 9 o'clock at night and I need someone to come talk to them about pee. So it tends to be used for more formal discussions, like a daily update of the plan, while a nurse's interaction is more minute-to-minute.

This observation indicates that there may be a conflict between the flexibility and availability of interpreters and the needs of the medical team. Most times, nurses simply can't anticipate when they might need the interpreter, and so they do not have the luxury of scheduling an appointment ahead of time. I should note that interpreter's schedules are often fully booked far in advance. Sometimes, interpreters are only able to respond to unscheduled patients (such as those in the Emergency room or in-patient units) when a scheduled patient does not show up for his or her appointment. In this case, the interpreter often checks in with the main office to identify other patients in need of interpretation.

One physician commented on the current under-use of interpreters:

... I think we feel good about ourselves if we've talked to the family once a day with the interpreter but I feel like the standard should be... every time you're talking to a family you use the interpreter. I also think that we need to make sure that we don't skip past families that don't speak English because I think that also happens and we don't talk to them as much as we talk to families that do speak English.

This standard of use is high in comparison to the current standard, but it is a change that is central to cultural competence. LEP families are often the most isolated in the hospital environment, and the support of interpreter services is necessary to facilitate communication and relationship-building, as well as to ensure that their children receive high quality care. Interpreter services and the rest of the medical team must work together to guarantee that these families do not fall through the cracks of the hospital system.

As a first step, the medical staff should be required to participate in a workshop or program that trains them to work effectively with interpreters. One interpreter commented frankly that, "Some doctors are just clueless, like they've never worked with an interpreter before." While this interpreter acknowledged that most providers are, in fact, familiar with the interpreters and show their appreciation for them, every staff member should be prepared to work with interpreters as a member of the team. The sort of program I suggest would allow providers and interpreters to interact outside of the medical encounter and begin to get to know each other. This sort of preliminary relationship building is currently absent, as one physician noted:

I do think we need a closer relationship with interpreter services and actually know who the people are, what their names are, what languages do they speak ... what are their experiences. I think it would also make it easy because the translator becomes a part of the team, but they're really not because we don't know them. They're just this person who comes on the floor to translate for 10 minutes.

This lack of familiarity and distance between interpreters and the rest of the medical team must be bridged in order to foster effective communication. One these two parties are gathered in one space, it is more likely that they may form a more cohesive medical team. A program that allows such interaction would also help to clarify the role of the interpreter in the team and debunk current myths about their specific responsibilities. For example, one interpreter expressed frustration that some providers wrongly assume it is her responsibility to transport patients throughout the hospital. Such role clarification would enable the team to work more smoothly, with each member showing respect to the other members.

A closer relationship between providers and interpreters would enable providers to better make use of interpreters as cultural brokers. One provider expressed her desire to tap interpreter knowledge:

...[M]aybe there needs to be an extra component to interpreter services... maybe... a component of teaching if they have someone who's a resource on the culture... [W]hat are the problems they see when they interact with physicians?...[W]e don't know. We just tell them, "Please say this" but maybe there's a better approach. Like, "When we're dealing with Spanish speaking patients you should do it this way." I think people would be open to that...

Without realizing, this provider touched upon one of the four conceptualizations of the role of the interpreter, the role as "manager of the cross-cultural/cross-language mediated clinical encounter" (Avery 2001). In this role, the interpreter strives to facilitate communication by, "providing the appropriate linguistic conversion from one language into another but also by actively assisting, when necessary, to overcome barriers to communication embedded in cultural, class, religious and other social differences" (Avery). Avery also notes how, in this social interaction, the interpreter has full

knowledge of what is going on, and therefore has “the power of information” that he or she must use to the benefit of both parties (2001). If both interpreters and the rest of the medical staff had the opportunity to communicate with one another, they might make progress toward this cooperative relationship.

There are also a few small but concrete changes that should be made to improve linguistic competence at Boston Hospital. Nurses suggested these changes, in large part, as they are most in-tune with the day-to-day needs of the Latino families that they work with. A first change they suggested was a translation of the food menu to have both English and Spanish descriptions. This minor change would make families feel more comfortable during their stay and would make it easier for nurses to order the food that children and their families would like to eat. One nurse also suggested that the menu be expanded to accommodate the preferences of families from different cultures. For example, Latino children might prefer tropical fruit juices as opposed to apple juice, though this is not currently an option. This seems like a trivial change, though it can make a big difference to a sick child in a foreign situation, as it may signal to a child that they are valued and that the staff wants to make them feel as comfortable as possible. Another important change is the provision of multilingual materials for patients. Increasing the number of multilingual signs, explanatory pamphlets, etc. would facilitate communication with families when interpreters are not available. Pamphlets describing basic procedures, illnesses, etc. should be available in Spanish, as well as many other languages, and should be written at an appropriate reading level. Currently, there is a pamphlet of basic words, phrases, and sentences available in many languages in the interpreter services office, but this resource is not often used on the in-patient units. In

fact, many of the providers that I spoke with were not aware that such pamphlets exist. These resources should be compiled into a binder that can be easily accessed by medical staff and used whenever in-person interpreters are not available.

Improving Diversity

Out of the 14 medical staff members I spoke with, only two (both nurses) mentioned the need for improved diversity within the medical team. Available literature, however, agrees that increased workforce diversity is an important element for creating a culturally competent environment while acknowledging that it is a challenge faced by hospitals across the nation (Betancourt et al. 2003:296). According to the Sullivan Commission on Diversity in the Healthcare Workforce, 6% of physicians and 9% of nurses identify as African American, Hispanic, or American Indians, while these populations compose more than 25% of the total US population (Sullivan 2004). In addition, the American Medical Association noted that only 3% of all physicians are Hispanic (Norwood). The Sullivan Commission noted that according to current trends, the healthcare workforce will fail even more dramatically to resemble the patient population in future years. This workforce crisis must be addressed, both at Boston Hospital and in other hospitals across the nation. Unfortunately, these discrepancies are rooted in a deeper history of social and educational discrimination.

The literature on cultural competence describes how patients often respond well to those from their same ethnic group or race, and this observation is supported by the responses of the respondents in my own study. One of the nurses who noted the need for diversity commented, “We do have such a diverse population of patients here and the staff does not reflect who we take care of on our floor.” Although creating a more diverse

workforce at Boston Hospital would take a significant amount of time, it would create a more welcoming environment for patients from different cultures and should be pursued by the administration.

Closing Remarks

The need for improved cultural competence is relevant to all of us, whether we are healthcare leaders, providers, patients, or simply concerned citizens seeking a more just and egalitarian healthcare system. No one would deny the importance of developing more welcoming institutions and training compassionate professionals to respond to the needs of a growing minority (soon to be majority) population that is exceptionally culturally diverse. Despite this general consensus, Americans are less likely to advocate for changes that would make the healthcare system more culturally competent and less likely to sustain current health care inequalities. According to a Commonwealth Fund report cultural competence has an important role in counteracting these inequalities (Betancourt et al. 2002). Although the authors note the current dearth of research on this connection, they note how, “Health care experts in government, managed care, academia, and community health care, on the other hand, make a clear connection between cultural competence, quality improvement, and the elimination of racial/ethnic disparities” (2002). Researchers, educators and policymakers should therefore prioritize efforts toward cultural competence.

How, then, can we begin to incorporate cultural competence on the systemic, organizational, and clinical levels? As I have noted throughout this case study of the pediatric in-patient units of Boston Hospital, there is no proven means to provide culturally competent care to the Latino population, or any other group for that matter. As

tempting as it may be, this model of care cannot be implemented by applying a standardized definition to medical practices throughout the country. In my focus on both the patient and provider perspectives on care, I have realized that true cultural competence exists amidst micro-scale interactions between these groups. If providers are trained to recognize the subtle yet critical ways that language and culture are manifested in every-day medical encounters, they can better respond to the needs of the families they serve. These individual, face-to-face encounters build upon each other to create a shared medical culture that is welcoming to diverse patient populations. In a modern version of the traditional Hippocratic Oath, Dr. Luis Lasagna wrote, “I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug” (1964). This wise observation included in the oath that every doctor takes is at the heart of cultural competence, as it hints at the understanding necessary to truly support and care for those from different cultural backgrounds.

Throughout this project, I sought to give voice to a variety of individuals and families at Boston Hospital, and in doing so I have learned a great number of things. I have come to appreciate the irreducibility of culture, as it is bound up with lived experience and its influence is often indescribable. I have glimpsed the complex workings of a hospital system and appreciated the struggles that many families face in navigating its barriers and bureaucracy. I also learned a great deal from the providers of Boston Hospital, as they are true leaders in their field, constantly striving to improve care for all families, regardless of their background. I hope I have done justice to the words of these patients and providers, and conveyed some of the valuable lessons they have taught

me throughout these pages. There remains a great deal to be done in order to meet the unique needs of the Latino population, but this work should serve as a first step towards creating a more culturally competent environment.

In every community, there is work to be done.

In every nation, there are wounds to heal.

In every heart, there is the power to do it.

-Marianne Williamson

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