What do non-English-speaking patients value in acute care? Cultural competency from the patient’s perspective: a qualitative study

Pamela Wish Garrett a*, Hugh Grant Dickson b, Lis-Young b, Anna Klinken Whelan c, & Roberto-Forero b

a Simpson Centre for Health Services Research, Liverpool Health Service, University of NSW, Sydney, Australia; b Medicine, Liverpool Hospital, University of NSW, Sydney, Australia; c Public Health, University of NSW, Sydney, Australia

Objective. The purpose of this research was to locate cultural competence within the experiential domain of the non-English-speaking patient.

Design. Seven language-specific focus groups were held with 59 hospital patients and carers of patients with limited English to better understand their experience and to identify critical factors leading to their constructions of care. Grounded theory analysis within a constructivist perspective was undertaken.

Results. While the majority of patients were positive about their hospital experience, the theme of powerlessness appeared central to many patient experiences. Language facilitation was the most common issue. Inattention to specific cultural mores and racism in some instances contributed to negative experiences. Patients primarily valued positive engagement, information and involvement, compassionate, kind and respectful treatment, and the negotiated involvement of their family.

Conclusion. Because of the specific nature of each patient–provider interaction within its particular social and political environment, culturally competent behaviour in one context may be culturally incompetent in another. We propose a model of cultural empowerment that reflects the phenomenological basis of cultural competence in that cultural competence must be consistently renegotiated with any particular patient in a particular healthcare context. Similarly, ongoing community consultations are needed for health services and organisations to retain cultural competence.

Keywords: cultural competence; non-English-speaking patient; consumer experience; ethnicity; cross-cultural study; grounded theory

Introduction

The purpose of this article is to locate conceptions of cultural competence within the experiential domain of the acute care patient.

Culturally competent care is a highly contested construct. It is frequently defined as behaviours, attitudes and policies that support a negotiated process of appropriately caring for people across languages and cultures (Cross et al. 1989, Kagawa-Singer and Blackhall 2001). Providers are expected to possess ‘cultural knowledge’, ‘respect for different cultural perspectives’, and skills to ‘use them in cross-cultural...
situations’ (Brach and Fraser 2000, p. 183). Cultural competency may emphasise the technical skills of providers (Campinha-Bacote 1999, Flores 2000, Papadopoulos et al. 2004, Kleinman and Benson 2006). A proliferation of models, often delineated by catchy acronyms, has been developed to outline components of effective cross-cultural healthcare communication. These include BATHE, BELIEF, ESFT, SUNRISE, CRASH and the 3D Puzzle Model (Leininger 1988, Stuart and Lieberman 1993, Betancourt et al. 1999, Dobbie et al. 2003, Rust et al. 2006, Schim et al. 2007).

Cultural competency may also refer to specific organisational, system or service attributes (Dreachslin 1996, Rutledge 2001) or policy imperatives which facilitate appropriate, equitable and accessible care (OMH 2001, NHMRC 2005).

Cultural competency has been variously viewed as a matter of social justice, a mechanism for addressing ethnic disparity in health services, a means of complying with governmental regulation, and a marketing strategy for private hospitals to increase market share and profits (Brach and Fraser 2002).

Many definitions conceive of cultural competency as a developmental journey for a health professional, a service, system or organisation, or a defined set of attributes that need to be attained. Commentators warn that some such approaches to cultural competency may over-emphasise ethnicity and trait-based factors associated with the patient, thus serving to exacerbate bias, stigma, stereotyping, and racism (Papps and Ramsden 1996, Johnston and Herzig 2006, Kleinman and Benson 2006, Lee and Farrell 2006).

Definitions of cultural competence tend to be based on provider and academic representations. Yet a great many aspects of culturally competent care are contextually and temporally based, in effect a social construction of the care process. Indeed, the same behaviour might be considered ‘culturally competent’ in one situation and quite incompetent in another (Manderson and Allotey 2003). The interpreted healthcare reality reflects the dynamism, complexity and also the very specific nature of each patient–provider interaction within its particular social and political environment. Patient constructions and evaluations should therefore inform, or even determine the discussion, rather than provider and academic perspectives.

Qualitative research exploring the views of hospital care of patients with limited English has contributed an important patient-based perspective to the debate about cultural competence. Such research has generally focused on single ethnic groups and/or on health events such as birth, death, palliation, and mental health problems (e.g., Rice and Naksook 1998, Campbell et al. 2000, Yeo et al. 2005). These studies often demonstrate customs and beliefs in variance to those of mainstream cultures. However, explorations of the day-to-day experiences and constructions of patients with limited English in acute medical settings are sparse. Further, the bulk of research material derives from US studies of African-Americans and Hispanics and these findings cannot always be transferred to multicultural settings with different political, historical or socio-linguistic traditions. This relatively narrow research scope may inadvertently contribute to those limited constructions of cultural competency, focused on ethnicity which critics have noted.
The purpose of this study was to use qualitative research to derive a conception of cultural competency based on acute patient experiences, views and constructions.

Methodology

Setting

The study was undertaken at Liverpool Tertiary Hospital, a hospital serving a large multicultural community in the western suburbs of Sydney, Australia.

Participants

Forty-nine patients and 10 carers from non-English-speaking (NES) backgrounds attended seven language-specific focus groups. This was part of a larger study of patient experience involving 360 NES acute patients, interviewed in a telephone survey conducted by trained bilingual research officers. The language groups included Arabic, Italian, Vietnamese, Chinese (Mandarin and Cantonese), Croatian, Serbian and Spanish. Telephone study participants had been patients at the Liverpool Hospital in 2004 whose admission data indicated they spoke a language other than English. All those successfully interviewed were invited by bilingual research officers to attend the language-appropriate focus group. No Greek or Cambodian group was held, as there were inadequate numbers in the study group.

Process

The Principal Investigator and one of the seven bilingual research officers co-facilitated each group, which was conducted in the relevant community language, with a professional healthcare interpreter formally interpreting proceedings.

Much literature has recognised the challenges associated with conducting research in the context of linguistic and cultural diversity, including the vulnerability of some minority groups, the insensitivity of some researchers, and the likelihood of significant resource, class, cultural and power differences between the researcher and their subjects (Allotey and Manderson 2003). Beyond these issues, the language barrier alone can preclude active ‘real time’ participation of the (non-bilingual) researcher (Klinken Whelan 2004). Our process adapted Klinken Whelan’s ‘rapid bilingual appraisal’ model (Klinken Whelan 2004). This model, devised for community participation and planning purposes, provides for a bilingual worker to conduct the focus group in the community language, while an interpreter whispers interpreted proceedings to the principal researcher. Our adaptation provided for the principal researcher, through the professional interpreter, to introduce and ask half the set focus group questions directly to the group, thus establishing her role as the principal researcher. The alternate questions were asked by the bilingual research officer, and were interpreted to the principal researcher and the (English-speaking) scribe. This process ensured that proceedings flowed, fully involved the principal researcher, and interactions were dynamic as they were conducted almost entirely in the community language in real time. Further, opportunities to capture linguistic, cultural and interpersonal nuances were maximised. As the linguistic data is filtered through the interpreters and bilingual research officers during the interpretation...
process, the presence of at least two bilingual participants helped ensure the quality of the interpretation. Each group proceeding was videotaped, audio-recorded, scribed (by the English-speaking research assistant) and fully transcribed into English.

Focus groups explored the overall hospital experience, the impact of limited English proficiency, access to interpreters, patient and family involvement in care, medications, waiting times, the discharge process, and support provided at home.

Ethics
Ethical clearance was obtained from the South Western Sydney Area Health Service Ethics Committee. Full consultation occurred with multicultural healthcare services. The Research Information Sheet was professionally interpreted and participants were assured of privacy and confidentiality. Written consent, co-signed by the interpreter, was obtained from each participant. Proceedings were locked in filing cabinets within the Research Centre.

Theoretical approach
Data was analysed using a constructivist grounded theory approach (Charmaz 2006). This theory assumes that the experience and the meanings attached to those experiences of both research participants and the researcher are constructions of reality. The grounded theory arising from the qualitative study is similarly viewed as a construction of reality. The implications of this approach are that the data must be sufficient and rich so as to allow the researcher to understand and effectively enter the ‘research participants’ world’ (Charmaz 2006, p. 19), while recognising their own role in constructing meaning from this data.

The methodological approach is represented in Figure 1.

Coding
English-language transcripts of the focus groups were read individually by the Principal Researcher and Co-Researchers. Data was divided into positive and negative experiences and reviewed to elucidate preliminary themes. Line-by-line open coding was undertaken, ‘sticking closely to the data’ (Charmaz 2006, p. 45). Codes were developed related to a broad range of themes, concepts/ideas, emotions/feelings, events and constructions. The same paragraph or sentence was frequently placed in two or three different codes, reflecting the richness and complexity of the data. A large number of codes were initially derived and these were carefully discussed and amalgamated into core codes and related sub-codes. Sub-codes were given names directly derived from the text in order to highlight patient experiences, understandings, underlying meanings and constructions. Each transcript was systematically re-checked against the revised codes and again refined. Codes and coding were then individually cross-checked and amended by the bilingual research officers. This process ensured that cultural and linguistic concepts were appropriately captured and assisted in validation of the coding. Coding differences between researchers were systematically discussed and codes amended accordingly.
**Findings**

*Overview*

Three out of five of the language groups were quite positive about their hospital and discharge experience. Many participants expressed happiness and gratitude to the hospital for their healthcare and for the positive health outcome. They trusted and expressed faith in biomedicine and in the clinicians caring for them. Many compared the care favourably with that expected in their country of origin and others specifically praised this hospital. The extent to which this represented social desirability or culturally derived politeness/acceptance is difficult to assess. Examples include:

- ‘I am very happy. I am proud of the Hospital’. (Arabic woman)
- ‘I felt the hospital response was very positive and professional’. (Italian man)

The participants equally expressed significant dissonance mostly related to their inability to directly communicate with providers. Limited English, lack of control and involvement in healthcare, social and economic circumstance and (sometimes) gender contributed to these events. The theme common to these negative events was
powerlessness. Powerlessness was related to physical frailty and reliance on a healthcare system in which the patient could not directly communicate, to negative experiences of healthcare including not being informed or involved, and experiences in which the patient’s expressed wishes were ignored or they felt poorly treated.

‘Sometimes I had no idea what was happening. I couldn’t understand’. (Chinese woman)
‘Every morning they came and gave me the medications and I had to take them, no consultation, no asking’. (Vietnamese woman)
‘I have felt frustrated because I wanted to express what I really felt, what was really happening (for me). To be able to express to the doctor what I really wanted’. (Spanish woman)
‘They remove my whole teeth, my upper teeth, they remove everything, so I couldn’t chew so now I don’t know what my life is, which direction my life would be going’. (Vietnamese man)
‘It was very hard experience for me in the hospital, I could not speak English and I was waiting all day, I had no money and I was so hungry and I still remember me thinking I couldn’t speak English, I wish I had studied some English’. (Vietnamese woman)

Patient views on their healthcare were coded into five core codes: Language Facilitation, Patient Beliefs, Family Involvement, Staff Attitudes and Organisational Issues, each with sub-codes (see Figure 2). Each of these will be discussed in detail and exemplars provided. Because of the richness of the data, some of the exemplars could extend over more than one of the codes or sub-codes.

**Language Facilitation**

Proficiency in English had an understandably significant effect on a NES patient’s hospital and discharge experience. The inability to communicate in English produced anxiety derived from stress, fear, poor confidence and a deep sense of dependency.

**Patient Beliefs**

Spiritual/religious beliefs
‘Thanks be to god’

Faith in healthcare
‘I believe what the doctor gives me’

Folk remedies
‘I have to keep warm’

Female modesty, gender issues
‘Even in my room there was a man’

**Family Involvement**

Care, love, support
‘Family used to spend the whole day in Hospital’

Shaping and constructing patient illness
‘Whatever N. (daughter) tells me then I know’

Facilitating communication
‘They used to call my son and tell him…’

Advocacy, mediation
‘See who’s responsible for this bad system’

**Powerlessness**

‘I had no idea what was happening’

**Organization Issues**

Service availability, accessibility, staffing
‘Waiting from midday to 8 o’clock’

**Staff Attitudes and Behaviours**

Consultation, information vs. poor consultation
‘They explained after every step’ vs. ‘No consultation, no asking’

Respectful, caring competence vs. neglectful incompetence
‘I ought to have been dead a long time ago’ vs. ‘They just left (me)… To fend for myself’

Figure 2. Codes and sub-codes.
Some blamed themselves for not learning English or reported feelings of poor self-esteem. At times this appeared to reflect the power differential between patient and provider. Inevitably poor proficiency in English prevented patients from expressing their healthcare needs adequately.

The communication barrier led to problems in care, in administration of medication, compliance and treatment. Patients reported not being able to understand anything at all, sign language miscommunication, problems in replying to questions, difficulties with the speed and complexity of language and difficulties in understanding medical terminology. Patients expressed concerns about not being able to express or contribute to simple aspects of their daily care such as reading a hospital menu or going to the toilet.

‘When the doctor comes I don’t know what’s happened to me, what I’ve got, because no one is here (to interpret). It scares me everyday . . .’. (Spanish-speaking woman)

‘Everybody who speaks English would feel well in themselves . . .’. (Arabic-speaking woman)

‘Some words I could understand, others no, because the doctors speak really fast’. (Spanish-speaking man)

‘It (not being able to speak English) is like being deaf or speechless’. (Arabic-speaking woman)

‘The worse thing was filling out the menu you can’t read’. (Croatian man)

‘Maybe a cleaner or somebody would help (bridge the language barrier)’. (Spanish-speaking man)

Professional interpreters were crucial for overcoming the language barrier and achieving accurate healthcare communication. They ‘sorted out’ problems for many patients with limited English at some point in their hospitalisation. However, their absence at key healthcare events such as doctor’s rounds, the emergency department, unscheduled consultations or when a medical issue arose was seen as a problem. Some patients said they did not know how to access a professional interpreter or that they believed interpreters were too busy to help.

‘For me I couldn’t understand . . . When I was spoken to in Croatian (by the interpreter) I felt like my heart had enlarged. I knew some English but since 1972 I hadn’t had any contact with English speaking people’. (Croatian man)

‘Even when there was no interpreter someone took me to have the blood test done, to have different tests done. Then when the interpreter came I started to tell them all about the symptoms’. (Vietnamese woman)

‘When the interpreter came then I could know what happened’. (Chinese woman)

‘I was not clear about this (how to access professional interpreters)’. (Chinese man)

‘If an interpreter is available I would have an interpreter but I know they are very busy’. (Chinese woman)

Language facilitation by bilingual staff was positively supported by a number of participants as they were seen as available for day-to-day assistance and connected in the system. However, two Arabic and one Spanish-speaking patient said that bilingual staff refused to speak to them in their community language.

‘It is lucky if you have a Vietnamese-speaking doctor who can help you’. (Vietnamese woman)

‘Sometimes they speak Arabic, the nurses speak Arabic . . . But they won’t talk in their language’. (Arabic-speaking woman)
**Patient Beliefs**

An emphasis on the retention of female modesty, especially when undressing or showering, was evident in the Arabic group, particularly among the Muslim women. They expressed a preference for female providers. The health service practice of placing men and women in the same ward (mixed gender wards) was seen negatively by people of both sexes in the Arabic, Italian and Serbian groups.

‘I kept telling them I am a Muslim woman I want a female nurse’. (Arabic woman)  
‘I don’t know if it happens in all the wards … but they put women with men, I wasn’t used to that’. (Spanish-speaking woman)  
‘Even in my room there was a man’. (Italian woman)

Many Arabic, Italian and Croatian patients integrated healthcare with spiritual and religious beliefs evidenced through thankful invocations to God. The central importance of God or higher spiritual beings seemed to help make sense of their experience. Some Vietnamese patients expressed fatalism or acceptance of quite negative healthcare events, which may also relate to a philosophical/spiritual tradition.

‘I went home and have been well. So now it’s good, thanks be to God’. (Croatian man)  
‘Again I want to stress that I am not complaining about this, I just am speaking out, this could be due to a lack of staff, shortage of staff’. (Vietnamese man)  
‘Thank God it healed this time’. (Croatian man)  
‘I thank God that until now I haven’t been (admitted) in hospital’. (Italian man)  
‘And thank God I am still walking’. (Spanish-speaking woman)

Medical practitioners and providers were often seen as beyond questioning, with a high reliance and belief in biomedicine. The extent to which these attitudes reflect social desirability within the research setting is uncertain.

‘From my experience I believe what the doctor gives me’. (Italian man)  
‘All the nurses, doctors, services are fantastic’. (Arabic man)

In the Chinese group, participants mentioned practices such as keeping warm (hot/cold concept of illness) and eating vitamins, implying belief in what is often referred to as ‘folk or alternative remedies’.

‘I have to keep warm. Keep warm, no cold water wash’. (Chinese woman)

**Family Involvement**

The family was critical to the welfare of many patients with limited English, as the basis for negotiating hospital care. Many families assumed almost total responsibility for decision-making. Family and relatives facilitated engagement with the healthcare providers, advocated for patients, provided love, practical support and care. Many patients and staff elected to use relatives as the language facilitators rather than attempting to access the interpreter service. To some extent family involvement reflected the collective culturally derived responsibility and obligatory roles that might be expected of the (extended) family unit in their country of origin. Some families were involved in response to their relative’s fears about not being able to directly communicate their needs, symptoms, signs and feelings.
Thus, family members frequently saw their relative as vulnerable, powerless and in need of constant vigilant protection. Indeed, some patients totally abrogated any role in directly communicating with healthcare staff or in understanding their illness.

‘She had three blockages and a leaking valve and that is why she is really, really scared’.
(Arabic carer discussing her auntie)

Relatives therefore had the role of understanding, shaping and constructing the patient’s illness, care and treatment. Illness experience was filtered through the eyes and ears of the family and the diagnosis, treatment and care was filtered back to the patient through their relative. When the family was facilitating communication this role of interpreting illness was more apparent.

(One Croatian woman explained), ‘Whatever Nardina (daughter) tells me then I know).
‘I came ... and explained to her (about the heart operation)’. (Arabic-speaking carer).
‘Maybe he told my daughter and maybe my daughter forgot to tell me and I drank water (before the operation)’. (Chinese woman)

The high expectations and obligations of (particularly) women carers were frequently described. Granddaughters, daughters, and daughter-in-laws were especially mentioned. It was clear in some instances that this reflected the gender roles in the household. Some relatives spent the entire day with the hospitalised patient, taking large amounts of time off work or school. This responsibility extended post-hospital discharge. Some families felt a burden in being required to be in attendance to ensure language facilitation and the safety of their relative.

‘I have a lot of family that used to spend the whole day in hospital’. (Spanish-speaking woman)
‘... it’s very frustrating, for the family there is a lot of pressure on because we have to make the time to be there to be the interpreter ... I had to take the full day off work’.
(Spanish-speaking carer)

Families mediated care and became responsible for advocating for patients.

‘She (the aunt) told me to come to see who’s responsible for this bad system in intensive care (lack of beds)’. (Arabic-speaking carer)
‘When I have problems I call my daughter and ask my daughter to talk to the doctor’.
(Chinese woman)

Patients with limited English were invariably reliant on their families for language facilitation. A few expressed concern that the family did not adequately understand the medical terminology or setting. Patients provided many examples of family interpreting which may conceivably have resulted in imperfect translation.

‘The patient talks in Arabic to Mum and to me and I tell it (in Assyrian) to my daughter and my daughter tells it in English to the doctor. So it was a perfect combination ...’.
(Assyrian woman)
‘(Having an) interpreter is good because my daughter, there are some things in the medical field that my daughter doesn’t know’. (Chinese woman)
‘In my case they used to call my son and tell him’. (Arabic-speaking woman)
‘My daughter was at my side so I didn’t ask for an interpreter’. (Chinese woman)
**Staff Attitudes and Behaviour**

Most of the expectations that patients had of staff were universally expected provider competencies. Respectful and caring attitudes, well-explained, consultative care was highly valued. In contrast, patients sometimes described fear, pain, negative events or suffering when staff were perceived as neglectful, authoritarian or racist. Some patients resented their lack of control over healthcare decision-making, for example, when providers spoke only to their family. Active engagement, consultation and information provision was highly valued.

‘Yes from the first moment, they explained, after every step, they explained what they would have to do next, and the kidneys, their function. I knew everything’. (Vietnamese woman)

Similarly, poor consultation, engagement or involvement was seen very negatively.

‘My op went on for 14 hours. The first question my wife asked the staff after (the operation) was about what it was I was having. Doctor told her that it was not cancer. My wife asked a second question if they had removed any bone from the face and used something from the (leg). But they said they didn’t do it ... After that I was very happy, ... But then after I got discharged from hospital that same doctor told me that I had got cancer. When I had plastic surgery, they told me they removed bone from my jaw and they put metal in its place. I was feeling puzzled’. (Vietnamese man)

‘My children spoke English, so they spoke to my children, but there was no interpreter for me’. (Vietnamese woman)

Patients valued the quality of care provided by the hospital, which many constructed as safe, competent and for which they were very grateful. Patients particularly valued staff behaving like compassionate and caring family members.

‘I ought to have been dead a long time ago. They have lengthened my life, it’s true’. (Italian man)

‘Even my children couldn’t have given me better care’. (Vietnamese woman)

‘The nurse calls me Mum and comes and hugs me and cares for me’. (Arabic-speaking woman)

A few patients perceived that they had received neglectful or physically abusive treatment. One Arabic-speaking patient described being hit on the arm and having her cannula roughly removed. Some believed staff did not provide the care required for their safety and survival. One Vietnamese woman described having her breathing tube disconnected, against her will, on transfer to a new ward which resulted in negative health consequences. Another man described being given medication, against his will.

‘Two days in hospital (after her operation) and they wanted her to walk and of course it was difficult for her so they dragged her and made her walk by force and the cut was opened again and then three or four months again they found that out the cut was open and they had to have a new operation. My sister was very upset and she wanted to complain and mama said please don’t make any trouble, you know’. (Arabic carer)

‘Nothing ... They could see I didn’t have my leg but in spite of that they didn’t ask me anything. They just left it to my resources, to fend for myself. If you can’t you just die’. (Croatian man)

‘I couldn’t talk because I had a tube down my throat and I didn’t want to wet my bed, I didn’t know what to do, I pressed the buzzer and no one came to my assistance but
luckily there was a plastic bag on the bedside and so I urinated into the plastic bag and I had to hold the plastic bag all night and I can't remember what I used to keep knocking at the bed and it took a long, long, long time till someone past by my door and happened to see me and then a person came up and helped’. (Vietnamese man)

This study found that only the Muslims within Arabic-speaking group mentioned events that were coded as racism. Racism was defined as a patient believing they were being treated less fairly or respectfully based on their race or ethnicity. One Muslim family suggested that the successive cancellation of an operation was related to the wearing of the hijab (scarf). Others mentioned poor understanding of the need for female providers and the retention of modesty. We have briefly outlined this finding elsewhere (Garrett and Forero 2006).

**Service and Organisational Issues**

The service quality, arrangement, availability and access to health technology was highly valued. Examples of organisational problems identified included poor timeliness of treatment, poor staffing, lack of access to bilingual staff and language services, and a lack of involvement of family and significant religious people in healthcare. Lack of staff was often mentioned as a systemic problem. ‘The Government’ was generally blamed.

‘When I brought my wife with broken her shoulder, I was waiting 7 hours in emergency waiting room. . . . The doctor left it like that and said to go and see the specialist the next day’. (Arabic-speaking man)

‘When the doctors do their rounds it would be good if they had a bilingual one (to) go with them’. (Vietnamese man)

‘Before we had more staff, more doctors, more nurses but now I see less of them. Probably they have cut down a lot on services for patients’. (Vietnamese man)

**Advocacy needs**

Several participants attended the groups with a view to resolving health or welfare issues. These issues ranged from domestic violence, need for home and personal care, concern about a speeding fine while racing to attend the emergency service, advocacy regarding the surgical waiting list, to a plea to find out from the doctor their diagnosis. These examples indicated the inability of the patient with limited English to understand and negotiate health and welfare services.

**Discussion**

Qualitative research across cultures and languages is challenging, complex and difficult. This analysis focused mainly on a textual analysis, which is an accurate record of the words interpreted by the HealthCare Interpreter. Despite our efforts, there may be subtle issues, innuendo, and information that have been ‘lost in translation’. The study is based on a series of narratives or remembered constructions of experience and the extent to which these emergent concepts are transferable to other settings and groups is always contentious.

NES patients often viewed their acute hospital experiences positively, although there was significant experience of negative events and the associated theme of
powerlessness. Service or system attributes and provider behaviours that were highly valued included appropriate language facilitation, patient and family information and involvement, respectful, kind, compassionate care, respect for cultural, religious and personal beliefs, and supportive systems and organisations.

Through integrating these derived attributes and behaviours with the relevant literature, it is possible to develop a series of domains of cultural competency. If these competencies are met, then the problems associated with powerlessness should be reduced. Just as powerlessness is central to the patient’s negative experience of healthcare, so empowerment must be central to competence. The model assumes that cultural competency must be constantly re-negotiated with any particular patient in a particular healthcare context. We have called this model The Cultural Empowerment Model (see Figure 3).

**Competency one: facilitating language**

As indicated in our study, language barriers presented the patient and the system with a variety of problems. The literature associates language barriers with access problems, poor compliance with physician instructions, more emergency room visits, more laboratory tests, less follow-up and less satisfaction with services (Derose and Baker 2000, Yeo 2004). People with little or no English are less likely to engender physician empathy, establish rapport, and receive information or be involved in medical decision-making (Ferguson and Candib 2002). Conversely, the presence of interpreters has been linked with improvements in access, health status, service utilisation, choice, quality, compliance and satisfaction (Brach and Fraser 2000, Karliner et al. 2007). Bilingual doctors and nurses assist by bridging language barriers, improving service suitability and accessibility, reducing opportunities for discriminatory attitudes, and increasing access and service participation (Perez-Stable et al. 1997, Johnson et al. 1998, Cooper-Patrick et al. 1999).

Using family and friends to interpret may compromise confidentiality, family relations, and healthcare quality and safety (Riddick 1998, Carrasquillo et al. 1999). Although many patients in our study preferred to use their relatives as language

![Figure 3. The Cultural Empowerment Model.](image-url)
facilitators, there were instances such as symptom description, diagnosis, treatment and prognosis which warranted professional healthcare interpretation, so that the integrity of information and confidentiality could be maximised.

Examples of this competency include usage of professional interpreters, usage of telephone interpreters, use of translated material, and use of the bilingual staff in direct healthcare provision.

**Competency two: negotiating family involvement**

Our study identified the importance of family involvement in healthcare in a range of roles including advocate, language facilitator, carer, mediator and information interpreter and shaper. For many of the patients with limited English, illness required relatives and friends to demonstrate their concern and support by gathering at the bedside, being highly involved in decision-making and taking strong caring responsibilities (Brach and Fraser 2000). There is a considerable literature that attributes these expectations to collectivist cultural values (Triandis 1994, Gardner et al. 1999, Oyserman et al. 2002). Although most patients in the study were heavily reliant on relatives and very willingly shared decision-making, a few wanted greater engagement and control.

Arguably, culturally competent care requires a negotiated agreement about the role of the family in the healthcare process and an understanding of the patient’s support network, environment and social context.

Examples of this competency might include: routinely privately asking patients about the nature and extent of the family’s involvement and requesting patients to sign waiver forms if they wish to fully disclose their medical information to their family or a specific family member (Clark and Vercler 2007).

**Competency three: understanding patient beliefs, expectations, experiences and constructions**

The study showed that patient beliefs were important in their healthcare. Constructions of the self and family, interpretations of signs and symptoms, conceptions of the body and mind, mechanisms for coping with sicknesses, religious or spiritual beliefs, the role of traditional and folk healers, and understanding of the healthcare system were sometimes highly variable and may derive from a large range of cultural influences including the patient’s ethnicity, gender, social status, religion, age, migration history or acculturation (Parsons 1990, Triandis 1994, Kleinman and Benson 2006). In short, a patient’s culture shapes their experience, understanding and construction of illness and disease (Manderson and Reid 1993, Kleinman 2004).

Divergence in the meaning and understanding of emotions, actions, and discourse can further complicate such negotiations. Although most human emotions and behaviours will be manifested in all cultures, accurate recognition, understanding and interpretation may vary (Bhui and Bhugra 2004). For example, gestures, posture, touch, indications of respect, demonstrations of emotion (including pain or sorrow), prioritisation, and ways of handling time and space can vary (Parsons 1990, Fortin 2002).
Kleinman and Benson (2006) recommend asking whether the patient’s ethnicity is an issue in the healthcare setting. Thus, the patient’s illness story can be located within an ethnic and social context that they themselves define.

Other specific examples of this competency might include: ensuring providers properly introduce themselves and outline their role to the patient and the family; seeking advice from interpreters, cultural mediators as well as the patient and their family with respect to care preferences; taking cues/advice from patients regarding the frequency and appropriateness of eye contact and touch; providing verbal indications of when a physical examination is commencing and explicitly seeking the patient’s agreement; providing an option for a provider of the same gender; taking extra care to respect modesty associated with undressing; providing hospital gowns which offer complete body coverage; ensuring where possible that mixed wards are not used when patients may find this unacceptable; and taking care to recognise that practices or beliefs common in a cultural group may not be adopted by everyone in that group (Clark and Vercler 2007).

**Competency four: being compassionate and respecting patient and human rights**

Patients in our study often expressed a desire to be fully and regularly informed, compassionately treated, and equitably involved in decision-making.

Stigma and negative social stereotypes, as recounted by some Muslim patients in our study, have been shown to negatively influence healthcare interactions (Lee et al. 2005). Physicians have been found to recommend different treatments for patient actors based on their race and sex (Schulman et al. 1999) and unequal medical treatment based on race has been demonstrated in the US (IOM 2003) and associated with disparities in health outcomes. Racial discrimination has been reported in Australia in the community (HREOC 2001) and in healthcare (Henry et al. 2004).

This competency implies the need to hold regular open conversations directly with patients (through interpreters) and their family in order to demonstrate empathy, kindness, compassion and respect (Papadopoulos et al. 2004). The patient’s right to make decisions about and control their own healthcare should be paramount. While providers are biomedical experts, informed decision-making remains the right of the patient (Clark and Vercler 2007). Empowerment is crucial to competent care.

**Competency five: negotiating a care partnership**

Understanding the illness as the patient experiences and constructs it is fundamental to positive communication. Models to achieve this have been proposed by several academics and clinicians (e.g., Kleinman et al. 1978, Flores 2000, Dennis and Small 2003, Kleinman and Benson 2006).

Effective cross-cultural interaction may be complicated by the power differential between the provider, who may focus clinically on ‘curing’ disease, and the patient, who may focus on their personal experience of illness (Kleinman et al. 1978). The biomedical and personal assumptions, pre-conceptions, biases, and beliefs of the provider may significantly influence the interaction (Campinha-Bacote 1999, Fortin 2002). Most commentators suggest that providers should have opportunities to
examine their own beliefs, values and assumptions about other people (Papps and Ramsden 1996).

This competency requires an open exploration of the patient and family’s view of the cause of the illness, when and why it started, its severity, the expected treatment and results, and what they call the problem (Kleinman et al. 1978). The medical history needs to include the usage of alternative types of healthcare such as herbs or acupuncture as this may be the preferred approach of some patients. The patient’s social and environmental context needs to be considered. Integrating the patient’s story with the provider’s constructions of the illness, sets the parameters for a partnership approach to negotiating treatment and care (Kleinman and Benson 2006). Such an approach requires that all treatment alternatives be empathically and respectfully discussed. Providers should be trained on the correct legal procedures to adopt in the uncommon situation that the recommended treatment is refused (Clark and Vercler 2007).

**Competency six: providing systems so services and providers can be competent**

This final component acknowledges the importance of policy, regulatory, systemic, and organisational change so that cultural competence can be developed in both providers and organisations (Dreachslin 1996, Rutledge 2001, NHMRC 2005, OMH 2007).

The culture of hospital care has been viewed as an interaction between the culture of medicine and western healthcare (biomedicine), the culture of the health professional and the culture of the patient: an interaction influenced and informed by the social and political context (Ong et al. 1995, Manderson and Allotey 2003).

Proactive diversity planning and management, professional education and development, service re-organisation, and targeted cross-cultural data collection and research can enhance organisational cultural competence. Integral to this is ongoing patient and community involvement so that planning, monitoring and evaluating care is a partnership and is continually updated.

Examples of provider behaviours associated with this competency might include managers ensuring signage is multilingual; establishing relationships with significant local religious leaders; taking into account food preferences and ensuring vegetarian food options are available; ensuring cultural competency education for staff; ensuring data collections include fields related to ability to speak English, need for an interpreter and language spoken at home; and developing plans to improve service/organisational access for people with limited English proficiency.

**Conclusion**

Definitions of culturally competent healthcare have been devised to address disparities in health status and service delivery, concerns about market share, and interest in social justice and equity (Brach and Fraser 2000). Most approaches have commenced with the views and constructions of providers, academics and researchers. We considered that it was timely to ask: What do NES patients really value in healthcare?

This study reminds us that cultural competency is primarily about responsive compassionate caring and empowerment. Humanness, attention to healthcare rights,
respect, empathy and most importantly effective communication were highly valued by non-English-speaking patients.

We found that ethnicity-based customs, beliefs and practices were at times important for non-English-speaking patients in acute healthcare. In this study, we found that broader personal and social factors such as powerlessness, patient and human rights, familial roles, language ability, religious and spiritual beliefs, socio-economic status, and gender, contributed most significantly to the non-English-speaking patient’s experience and construction of illness (Manderson and Reid 1993).

Culturally competent care is concerned with those very specific, dynamic and personal patient–provider interactions that occur within a particular healthcare context. While there are clearly skills which providers and services require so as to work effectively cross-culturally, cultural competence should not be viewed as a static set of such attributes or skills, nor as ‘knowledge’ of a list of ethnicity-based traits which patients may exhibit. Rather cultural competence is better understood as a canvass or template which can only be filled through ongoing compassionate negotiation and discussion between patients and healthcare providers and between communities and healthcare services.

References


National Health & Medical Research Council (NHMRC), 2005. *Cultural competency in health: a guide for policy, partnerships and participation*. Canberra, Australia: NHMRC.


Rust, G., *et al.*, 2006. A crash-course in cultural competence. *Ethnicity & Disease*, 16 (2 Suppl. 3), S3-29–S3-36.


