Getting Minority Patients' Points of View about Cultural Barriers to Health Care

Research to better understand the cultural perspective of minority patients

**SUMMARY**

Researchers at the University of California, Davis, conducted in-depth interviews with 38 Mexican and 45 Vietnamese immigrants at medical facilities in Northern California to understand minority and immigrant patients' views and experiences of cultural barriers in health care in the United States.

The study was part of a three-phase project designed to explore how policy-makers and health care professionals construct their notions of "culturally competent" health care.

**Key Findings**

- Patients offered limited response to direct questions such as, "Do you think there are cultural differences between you and your doctor?" or "Have you ever felt that your doctors fail to understand your culture?" "Culture" is an elusive term, the researchers explained. Researchers will need to formulate better questions than are currently used in many clinics if they seek to learn how culture works in these patients' clinical encounters.

- Contrary to expectation, not all patients expressed a preference for a physician of their own racial/ethnic group.

- The "vast majority" of patients wanted more health care providers who spoke their language.

- Age and geographic background influenced some patients' choice and preference for alternative therapies over allopathic (conventional) medicines.

- Some patients in both groups said the care they received at community clinics was "second class" compared with the health services that were available at hospitals and private clinics.
Funding

The Robert Wood Johnson Foundation (RWJF) provided an unsolicited grant of $70,361 from January 2006 to May 2008 to support the final phase of the three-part project, which involved interviews with Vietnamese and Mexican immigrants.

THE PROBLEM

In a March 2003 report (Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care), the Institute of Medicine documented that even when income, insurance and medical conditions are similar, people of minority and ethnic backgrounds in the United States generally receive a poorer quality of medical treatment than do others.

In the wake of these findings, public health officials coined the term "cultural competency" to denote an array of efforts designed to provide quality care to patients regardless of their race, ethnicity, culture or language. (Betancourt JR et al., Health Affairs, 24(2): 499–505, 2005; available online.) Examples of these efforts have included:

- Sensitivity training of physicians and other health care providers.
- Patient support services, such as translators.
- Ethnicity-specific health campaigns.

Although such efforts have been significant, they often overlook the cultural diversity inherent within individual racial and ethnic groups, said Ming-Cheng M. Lo, PhD, of the department of sociology at the University of California, Davis. They have also tended to ignore the effects that context can have on the way ethnic and immigrant groups behave: specifically, how an encounter with Western medical "culture" can shape the way these groups interact with the U.S. health care system.

In an attempt to understand how policy-makers and health care professionals construct their notions of culturally competent health care, Lo and colleagues designed a three-phase research project, the first two parts of which the University of California, Davis, and the American Sociological Association funded:

- In the first phase, they examined data documenting the public discussion that took place in formulating responses to findings in the Unequal Treatment report.
- In the second phase, they interviewed some 50 physicians in Northern California to capture their experience with immigrant communities and their understanding of cultural competence.
- In the final phase, they proposed interviewing Mexican and Vietnamese immigrants to explore their perceptions of cultural barriers in health care in the United States.
CONTEXT

RWJF issued Grant ID# 055258 under the auspices of its Disparities team (since subsumed into RWJF's Quality/Equality team). The aim was to ensure that all Americans have access to quality health care by eliminating the gaps in care experienced by racial and ethnic minorities. RWJF's efforts centered on improving understanding of the multiple factors that lead to racial and ethnic minorities receiving poorer quality care and on working directly with health care systems to improve the quality of care for all patients.

THE PROJECT

Under this grant, researchers at the University of California, Davis, interviewed Mexican and Vietnamese immigrants at medical facilities in Northern California to understand minority and immigrant patients' views and experiences of cultural barriers in U.S. health care. The study was the last phase of a three-part project designed to explore how policymakers and health care professionals in the United States construct their notions of "culturally competent" health care.

Methodology

The study involved semi-structured, in-depth interviews lasting one and a half to three hours with 38 Mexican and 45 Vietnamese immigrants with limited English proficiency. The researchers recruited and trained research assistants fluent in the patients' native languages to conduct or interpret during the interviews.

They recruited patients from four primary care treatment sites in Northern California:

- A teaching hospital.
- Spanish-speaking community clinic.
- Community clinic offering care to multiple Asian communities.
- Multi-ethnic community clinic.

The researchers offered interviewees a small fee for their participation ($30 if the interview was completed in their language; $50 if the interview was conducted in English through an interpreter, because these interviews would take longer). In addition, they encouraged Mexican immigrants to "spread the word" to other people who might be interested in participating in the project. (See Lessons Learned.)
FINDINGS

The researchers reported the following findings based on the interviews with Mexican and Vietnamese immigrants in a report to RWJF:

- **Patients offered limited response to direct questions such as, "Do you think there are cultural differences between you and your doctor?" or "Have you ever felt that your doctors fail to understand your culture?"** "Culture" is an elusive term, the researchers explained. Researchers will need to formulate better questions than are currently used in many clinics if they seek to learn how culture works in these patients' clinical encounters.

- **Contrary to expectation, not all patients expressed a preference for a physician of their own racial/ethnic group.** Though earlier studies promoted "racial/ethnic concordance" between health care providers and patients to improve communication and patient participation, many of the Mexican and Vietnamese immigrants interviewed said they preferred White doctors because physicians from their own group "discriminated" against them, appeared "arrogant," provided inferior services or engaged in fraudulent activities to extract more money from patients. Interviewees who did express a preference for a physician from their own group said that shared language facilitated a smoother flow of communication.

- **Citing horror stories of miscommunication in the clinical setting due to language barriers, the "vast majority" of patients wanted more health care providers who spoke their language.** Patients usually said this would facilitate better communication between patients and their providers because conversations would not be mediated by a third party. However, a few patients who had endured serious illness or extended stays in the hospital said in the end they preferred providers with greater professional skills and experience, regardless of the language spoken.

- **When an interpreter was needed, some patients preferred a family member because they felt greater intimacy with that person, while others favored professional interpreters because of their technical abilities.** Patients who preferred family members as interpreters said they were more comfortable sharing personal and health-related information with someone who knew them, and they talked about this person being able to better serve as an advocate for them. Patients who preferred a professional translator often worried that private or sensitive information could be shared with others in their social circle.

- **Age and geographic background influenced some patients' choice and preference for alternative therapies over allopathic medicines.** Older patients originally from rural areas tended to favor "traditional" herbal and other alternative therapies because they were cheaper and more readily available. Younger patients from more urban areas expressed a sense of trust, security and admiration for the Western, science-based model of medical care and treatment.
● Negative experiences in their native country led some patients to express reluctance to share with physicians their use of alternative therapies. Several Mexican immigrants relayed their experience with doctors in urban Mexico who had dismissed their use of traditional remedies as outdated remnants of folk practices with no place in "modern" Mexico.

● Some patients in both groups said the care they received at community clinics was "second class" compared with the health services that were available at hospitals and private clinics. At the same time, they appreciated the access to care that these clinics afforded to uninsured and underserved groups.

LESSONS LEARNED

1. A number of strategies can prove helpful in recruitment of interviewees among hard-to-reach groups of patients. The researchers found that paying interviewees a small fee for their participation, asking interviewees to encourage others to participate and recruiting and training research assistants fluent in the interviewees’ languages were techniques that helped overcome barriers to interviewees’ participation in a research project, such as language, potential mistrust and long work hours. (Lo/Project Director)

AFTERWARD

The researchers are drafting papers based on their continuing analyses of the interviews with the Mexican and Vietnamese immigrants.

They published a theoretical paper, based in part on the first phase of the project, outlining a conceptual model for understanding the role of culture in the clinical encounter (Sociology of Health and Illness, 30(5): 741–755, 2008; available online.)

They also completed a paper, based on the second phase of the project, "Collaborative Narratives: Primary Care Physicians and Culturally Competent Healthcare," and have submitted it for publication to a peer-reviewed publication.