

barriers

behavior

outcomes

communication

culture

**A Facilitator's Guide  
to the Video**

# Community Voices

EXPLORING CROSS-CULTURAL CARE  
Through Cancer

health

"How are we . . . going to do our work,  
to drive better health outcomes among  
the people we serve? Well, we have to pay  
attention to all of the voices that matter."

**Ken Fox, M.D.**

Pediatrician, Boston Medical Center

Medical Anthropologist, Harvard Medical School

cancer

patient

prevention

social context

disparities

illness

behavior

treatment

language

ethnicity

stereotype

care

diagnosis

beliefs



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## Dear Colleague,

It is our pleasure at the Harvard Center for Cancer Prevention to provide you with *Community Voices*. In partnership with a wide range of community, health care, and academic leaders, we have produced this innovative video and facilitator's guide. These materials aim to advance current efforts at integrating cultural awareness and skill building into training for health professionals.

The *Community Voices* video consists of seven 10-minute segments developed to educate a range of health care professionals about the challenges and rewards of cross-cultural care. The theme of cancer – particularly cancer prevention and screening – serves as a lens through which to explore how culture comes to bear on all kinds of illnesses. Through compelling interviews with patients, medical interpreters, community health outreach workers, social workers, physicians, and nurses, *Community Voices* offers a fascinating range of perspectives rarely heard together.

Each of the seven segments in *Community Voices* addresses an important aspect in cross-cultural care. When used in conjunction with the enclosed facilitator's guide, the segments are intended to trigger discussion among viewers and can be used independently or in concert.

We encourage you to share the *Community Voices* video and facilitator's guide with colleagues in your organization or institution. We hope you find these materials useful in your work and we welcome your feedback.

Please email the Harvard Center for Cancer Prevention: [hccp@hsph.harvard.edu](mailto:hccp@hsph.harvard.edu) or call us at (617) 432-0038 with questions or comments, or for additional suggestions on how best to use *Community Voices*. We look forward to working with you in our joint efforts to promote high-quality cross-cultural care.

Sincerely,

Graham Colditz, MD, DrPH  
Jennie Greene, MS  
Kimberly Newell, MD

*A production of the*

**Harvard Center for Cancer Prevention  
Harvard School of Public Health**

*in association with*

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# The Goals

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When used in conjunction with this guide and facilitated discussion, *Community Voices* aims to help health professionals:

- recognize the complex ways in which culture comes to bear on health and health care
- identify areas where health attitudes, beliefs, and behaviors are particularly affected by culture
- become sensitive to cues that indicate that culture may be affecting the relationship between a provider and a patient or client, and develop strategies to overcome related barriers
- appreciate the complexity of the concept of culture and the closely related issues of race, ethnicity, socioeconomic status, and power
- recognize the diversity that may exist within a given culture
- understand the value of a multidisciplinary and multicultural team approach to medical and public health work

# The Audience

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*Community Voices* is aimed at students and professionals in a range of fields, including:

- |                 |                         |                         |
|-----------------|-------------------------|-------------------------|
| • medicine      | • nursing               | • health communication  |
| • psychology    | • public health         | • community development |
| • social work   | • health administration | • preventive medicine   |
| • health policy | • health education      | • oncology              |

The lessons learned from *Community Voices* can be applied in several arenas of health care. These lessons will inform health professionals as they interact with individual patients or clients, set priorities and policies at the organizational or institutional level, or work to affect broader social policy.

# The Lens

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Because cancer is a disease with significant disparities in risks and outcomes along racial and ethnic lines, it serves as a lens through which to explore how culture comes to bear on health and health care in the U.S. Yet the lessons viewers learn from *Community Voices* are not limited to cancer, because many of the issues relevant to cancer prevention, screening, and treatment also arise in the context of other illnesses. *Community Voices* is not intended only for those whose work involves cancer, but for anyone committed to promoting health among diverse people and populations.

# Notes from the Producers

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## The Mission

Research increasingly demonstrates that difference matters in health care. Difference in culture. Difference in race or ethnicity. Difference in socioeconomic status. Difference in health beliefs and practices. Difference matters in terms of people's experiences, their behaviors, the care they receive, and the outcomes of that care. In order to address the disparities in health and health care that exist in the U.S., we as health professionals need to understand how difference can affect care and develop skills to negotiate these differences.

The stories told in *Community Voices* help viewers understand how difference affects the way patients and clients experience illness, the way they experience health care, and the complex forces that influence their health behaviors and decisions. *Community Voices* aims to help viewers to not only step outside themselves and consider the world of their patients and clients, but also to reflect on their own cultural backgrounds and the culture of biomedicine itself. By watching and discussing the video, viewers will become better able to provide high quality, culturally appropriate care to the people they serve.

## Notes on the Video

- Rather than present profiles of different cultural groups as some educational materials do, *Community Voices* offers a thematic approach to the subject of cross-cultural care. Our segments focus on major themes such as language, help-seeking behaviors, and core cultural issues, rather than specific cultures or common characteristics of those cultures. We have taken this approach for two important reasons. First, cultural profiles often overlook the heterogeneity that may exist among individuals who are generally considered to be of the same culture. Second, particularly given time constraints, it is unrealistic that, as professionals, we will become "experts" on all of the cultures we may encounter in our work. What we can be expected to recognize, however, are key areas of health in which culture is often relevant.
- *Community Voices* aims to underscore the importance of individual health beliefs and behaviors. To help discourage viewers from considering the people featured in the video as representative of particular communities or cultures, *Community Voices* does not explicitly identify interviewees' backgrounds. It is only when interviewees themselves describe their cultural backgrounds or talk about beliefs and practices common "in my community" that this information is disclosed.

- Although many of the issues addressed in *Community Voices* are more prominent in some communities than in others, many are quite universal. We have intentionally included comments that might, for instance, apply equally to a native-born non-Hispanic white person and to a recent immigrant. The video aims to address differences as well as similarities among individuals and populations.
- The aim of *Community Voices* is to present diverse voices, but it does not and cannot include everyone. The video does not, for instance, feature people of every race, ethnicity, age, sexual orientation, or socioeconomic level. Although the video includes the voices of a wide range of individuals, it is largely a springboard from which viewers can continue to learn about the vast diversity that exists in the US.
- Although *Community Voices* focuses on the cultures of patients or clients, we have attempted to demonstrate that difference also involves the culture of the health care professional. Many of the recommended discussion points offered in this guide encourage the viewer to consider his or her own cultural background, the culture of the institution in which he or she practices, and the culture of biomedicine itself.
- *Community Voices* is an introduction to the subject of cross-cultural care. It is a survey of key issues. Viewers should not expect to receive conclusions or directives. It is left to the facilitator – and ultimately the viewer – to further explore the often subtle and complex issues addressed in the video. To aid in this process, this facilitator's guide provides discussion points for each segment of *Community Voices*.

## Potential Pitfalls

Although cross-cultural health care is a critically important subject, it is also one ripe with potential pitfalls. We have attempted to address many of these pitfalls in both the video and this guide. Some of the difficulties that may arise when discussing culture are:<sup>1</sup>

- issues of terminology
- tendency to equate culture with race or socioeconomic status
- potential for stereotyping or reductionism
- tendency to see culture as a problem
- tendency to regard culture as esoteric
- tendency to ignore racism

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<sup>1</sup> This list was compiled based on suggestions from conversations with various scholars including Arthur Kleinman of Harvard University and Jerry Johnson of the University of Pennsylvania.

We have attempted to address and avoid many of these pitfalls in *Community Voices*. However, these issues are complex and important, and addressing them directly in facilitated discussion will help to prevent the unintentional misuse of concepts related to culture and cross-cultural health care.

## The Themes

The general themes addressed in *Community Voices* were primarily identified in three ways: a review of social science and medical literature related to cross-cultural health care and health disparities; conversations with numerous academics, including medical anthropologists, sociologists, physicians, and nurse educators; and the series of focus groups described below. Based on this research, we divided *Community Voices* into the seven segments listed on the following page. Our method is just one approach to conceptualizing the many ways in which difference can impact health and health care.

## The Voices

The people featured in *Community Voices* were identified in a number of ways. Working with Action for Boston Community Development (ABCD) and Cambridge Health Alliance, we conducted six group discussions with members of various communities in the Boston area. These groups included patients, medical interpreters, community health workers, and health educators from a range of cultures. The discussions elicited participants' views on health and illness, with a focus on cancer. Participants also shared their perceptions of and experiences with the U.S. health care system. We met many of the people featured in *Community Voices* during these discussions. Other people were referred to us by colleagues and friends, and still others we met at seminars and conferences that addressed cross-cultural care.

Many of the people featured in the video both work in the field of health care and are themselves members of diverse racial or ethnic communities. It is the voices of these people, speaking at once as health professionals, consumers of health care, and members of families and communities, that make up *Community Voices*.

# Tips for Use

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*Community Voices* was designed to inspire reflection and dialog among viewers, which makes group discussion an important component of its use. The following tips may be useful for discussion facilitators:

- Tailor and supplement discussion points based on the group being facilitated.
- Acknowledge that many of the answers seem “obvious” in theory, but are quite complex in practice.
- Personalize the questions posed to the group to move the discussion beyond abstract and often “easy” answers.
- Emphasize that cross-cultural care involves understanding, communication, and compromise from both sides – the provider and the patient or client

The discussion points offered in the following pages include an initial statement – often a quotation from the video or an issue raised in the video – followed by related questions that can be posed to the group. Because the discussion points often refer by name to individuals in the video, we have provided their names and photographs in the “References” section of this Guide.

It should be noted that this is not a complete list of discussion points, nor will all of the points or questions be relevant to all audiences. The facilitator is encouraged to tailor the points and the language used so that it is appropriate for the particular group.

We hope that *Community Voices* will inspire both facilitators and viewers to be creative – to take the discussion in directions we might never have expected. While showing the video, facilitators may want to encourage viewers to take notes about things that strike them and issues that they would like to discuss as a group. These notes can significantly enrich conversation.

As a facilitator, it is important to keep in mind that many people find it easy to discuss issues related to cross-cultural care and to identify what should be done about them in the context of a discussion or training session. In real life, however, it is often more difficult to translate such insights into practical ways to better accommodate those we serve. For example, most people would agree that patients should be treated with respect – this is not a blinding insight. But the reality is that many patients do not feel respected. What does one do, exactly, to demonstrate respect to people in clinical interactions? Addressing these very concrete questions by soliciting personal experiences will help to push the conversation beyond the abstract and often “easy” answers, and help participants integrate their new knowledge into practice.



Another goal of facilitated discussion is to help viewers better understand the cultures, health beliefs, and practices of their patients and clients. Although *Community Voices* focuses primarily on the experiences of patients and clients, we hope that the discussion will lead viewers to also reflect on their own cultures, beliefs, and practices. We encourage facilitators to reinforce the idea that cross-cultural care involves understanding, communication, and compromise on the part of both the health professional and the patient or client.

## The Segments / Discussion Points

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<b>Introduction</b> .....	11
An introduction to the subject of cross-cultural health care and cancer, with relevant quotations, and statistics. <i>Running Time 8 minutes</i>	
<b>Language, Interpretation, and Communication Styles</b> .....	13
How do diverse languages and communication styles impact health care interactions? <i>Running Time 10 minutes</i>	
<b>Meanings of Illness</b> .....	16
How do meanings attributed to illness impact people's experience of illness? <i>Running Time 8 minutes</i>	
<b>Help Seeking</b> .....	19
What do people do to promote health or treat illness and why? <i>Running Time 9 minutes</i>	
<b>Social and Historical Context</b> .....	22
How do social context and personal history impact health behaviors? <i>Running Time 13 minutes</i>	
<b>Core Cultural Issues</b> .....	24
How do values regarding authority, gender, physical contact, decision making, and religion affect health? <i>Running Time 13 minutes</i>	
<b>Building Bridges</b> .....	28
How can we work together to provide high-quality care to diverse individuals and communities? <i>Running Time 4 minutes</i>	

# Introduction *Running time: 8 minutes*

**Summary:** This segment introduces the concepts of culture, cancer, and cross-cultural health care by providing some key statistics about demographic changes in the U.S., racial and ethnic disparities in health, and cancer incidence and mortality. This segment also introduces some of the people featured in the video and poses general questions that will be addressed in the segments that follow.

## Learning Objectives

After watching and discussing this segment, viewers will be better able to:

- discuss demographic changes in the U.S. and their impact on the health professions
- describe some of the challenges involved in defining culture, race, and ethnicity
- explain some of the many ways that social and cultural factors affect health and health care

## Discussion Points

As Ken Fox notes, this country is undergoing significant demographic changes.

- How are these changes affecting the health professions?
- What challenges do these changes present?
- What benefits do they present?
- Have these changes affected your work? In what ways?

The terms “culture,” “race,” and “ethnicity” are often used interchangeably.

- Are they interchangeable?
- How are they similar?
- How are they different?

When culture is considered as a factor in providing health care, it is often seen as a barrier to delivering effective care.

- What is your opinion?
- What are some ways in which culture can help promote, rather than undermine, health?
- Why might some populations be healthier than others?

As this segment suggests, significant health disparities exist in this country, and they often break along racial and ethnic lines. For instance, prostate cancer rates among African American men are the highest known rates in the world.

- Why might this be the case?
- Why might other types of cancer and other diseases affect certain racial and ethnic groups more than others?
- Why are some diseases less prevalent in certain racial and ethnic groups?

Even well-intentioned and well-trained health professionals may inadvertently contribute to the disparities in health that exist in the U.S.

- What are some of the ways this might happen?
- Can you think of ways in which you personally may contribute to this problem?
- What are some strategies to help reduce these disparities?

There are two main tendencies in medicine regarding the impact of culture on health.<sup>2</sup> The first is to assume a great deal about someone based on his or her cultural background, and the second is to assume almost nothing about someone based on his or her background, in an effort to “treat all patients the same.”

- What are the risks and benefits of each approach?
- How can a balance between these two extremes be achieved?
- Can you think of instances in your own life, either in your role as a professional or a patient, when either of these dynamics seemed to be at work?

*Community Voices* consists of interviews with 16 people. In this first segment, only two people – Ken Fox and Karen Wolf – are identified. In subsequent segments, the other individuals are also identified by name and, in most cases, job title. (If you are using subsequent segments of the video as well, we suggest that you revisit this question.)

- Who are these other individuals?
- What do they do?
- What do you think are their racial, ethnic, or cultural backgrounds?
- What, if any, effect on you as a viewer would identifying these people by race, ethnicity, or culture have had?
- What are the pros and cons of not identifying them by race, ethnicity, or culture?

In this segment and throughout the video, individuals refer to beliefs and practices common “in my community.” For example, Atika Kouhail comments, “Cancer for my community is death.”

- Who has the authority to speak about a particular community?
- What are the benefits and risks of a statement like hers?
- Are communities homogenous groups?
- What kinds of differences may exist between members of the same community?

Some non-Hispanic white people in the U.S. consider themselves to be cultureless or do not consider it a large part of their identity.

- Is anyone, in fact, cultureless?
- Do you tend to assume that non-Hispanic white people in the U.S. have less distinct cultural identities?
- What was your reaction to Ric Blake, the non-Hispanic white man who appears briefly in this segment?
- What were your assumptions about his culture?
- How would you describe your own cultural background?

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<sup>2</sup> Ogur, B., “Community & Cultural Diversity in Medical Practice,” lecture for Primary Care Internal Medicine Principles and Practice, November 9, 2000.

# Language, Interpretation, and Communication Styles *Running time: 10 minutes*

## How do diverse languages and communication styles affect health care interactions?

**Summary:** Non-English speakers often have lower levels of satisfaction regarding communication with their providers, and research also suggests that they may receive lower quality care.<sup>3</sup> This segment explores how language and communication styles – what is said, how it is said, and how it is understood – affect health care. Issues regarding spoken and written language as well as non-verbal communication are addressed. The role of the medical interpreter in the clinical encounter is also explored.

### Learning Objectives

After watching and discussing this segment, viewers will be better able to:

- discuss the impact of language on patient-provider communication
- examine the roles of trained and untrained interpreters, including family members
- describe the impact that language, literacy, and the use of medical terminology have on health access and communication
- explain the impact of culturally-informed communication styles on health care interactions
- articulate the importance of a team approach to providing health care

### Discussion Points

When referring to people with limited English language skills, Maude Guerrier comments, “When they go to a provider, they go to a clinic or a hospital, they know they don’t speak the language. They already feel insecure.”

- How might this insecurity influence whether or not a person seeks care?
- How might it affect provider-patient interactions?
- If you have ever sought health care in a country where English was not spoken, what was your experience like?

Karen Wolf tells the story of a Muslim patient with diabetes. She learns from the interpreter that he is planning to fast for Ramadan, which could be dangerous to his health.

- What is the role of the interpreter in this particular case?
- Is the interpreter primarily a translator, or is he or she a cultural liaison as well?
- In general, what is the ideal role of interpreters?

There are various reasons why medical interpreters may not be used as widely and as often as they could be.

- What are some of the reasons?
- What are some of the reasons that providers may prefer not to work with interpreters?
- If you have ever worked with a medical interpreter, what did you like or dislike about the experience?
- What are some of the reasons that hospitals might not provide interpreters?
- What can be done to ensure that trained interpreters are more readily available?
- *Related discussion points include: interpreter training/certification, financing, and state legislation governing the provision of interpreter services.*

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<sup>3</sup> For example, Carrasquillo, O.; Orav, E.J.; Brennan, T.A.; Burstin, H.R., “Impact of Language Barriers on Patient Satisfaction in an Emergency Department,” *Journal of General Internal Medicine*, 14 (2), 82-87.

Maude Guerrier and Isabel Pintofranco both mention that family members often translate for non-English speaking patients.

- What are some of the risks and benefits of having a family member translate?
- What should be done if there is no one else available to translate?
- Is a family member preferable to untrained hospital staff, such as kitchen staff or janitors?
- What should be done if either the patient or family member is insistent that the relative translate?
- Are there certain circumstances when family members should or should not translate?
- *Related discussion points include: patient privacy, issues of gender and power, inaccurate interpretation, and psychological impact on children who interpret for family members.*

Halima Ali, who is an interpreter, says that as a young woman, there are certain subjects that are often difficult for her to discuss with older patients.

- What might some of these subjects be?
- In addition to age, what other factors might affect interpreter-patient communication? (e.g. education level, religion, gender)
- How might the interpreter-patient dynamic affect the provider-patient interaction and the quality of care delivered?

Sok Man Kwong explains that she once received a call to go in for radiotherapy but ignored the recommendation because she didn't know what "radiotherapy" was.

- What is the significance of this story?
- What are other ways in which use of medical terminology can undermine health care?
- Why do providers use this specialized language?
- Are there times that using medical terminology is appropriate and times when it is not?
- Does this have anything to do with the patient and his or her background?
- When do you tend to use medical terminology? Why?

Both Mojdeh Rohani and Elly Rodriguez-Decker comment that when patients don't speak English, they are sometimes "brushed away" or given less information than English-speaking patients.

- Do you think this is often the case?
- Why might people feel that they are being dismissed?
- Are providers less likely to offer information and explanation to patients whose English is limited?
- What assumptions, if any, are often made about non-English speakers in the U.S.?
- Can you think of times when you may have treated people a certain way based on their language proficiency?

Idi Jawarakim talks about the Haitian use of the term "gaz" and Carline Louizia discusses the use of the expression "my stomach hurts" in Creole. These are both good examples of concepts and terminology that may exist in one culture but not in another.

- What are other examples of words or concepts common in one language or culture that cannot be translated directly?
- What are examples of words or concepts common in US culture that would not be easily understood in other cultures?
- How does this discussion relate to the role of the medical interpreter?

Idi Jawarkim and Gladys Barrientos talk about use of numbers in giving and eliciting health information.

- When, if ever, are numbers useful with patients or clients?
- When are they useful when communicating with fellow health care professionals?
- If you used the video's introduction, were the statistics cited compelling or convincing? Why or why not?

Carline Louizia offers a good example of the complexity of translating written materials from English when she explains that although all Haitians speak Creole, many do not read the language. Instead, they read French because most Haitian schools taught French for many years.

- What are other examples of challenges in translating written materials?
- Is it enough to translate materials word for word into another language?
- What are some ways to ensure that educational materials are culturally appropriate?

Gladys Barrientos says, "It's not the language that you really speak. It's how you are to deal with that person."

- What do you think she means?
- How does non-verbal communication affect health care interactions?
- What are some examples of non-verbal gestures that are often used?
- What are examples of communication styles or gestures that might be acceptable in certain cultures and unacceptable in others? (e.g. eye contact or shaking hands)
- How can providers know what is the most appropriate way to interact with a particular patient or client?
- Can you think of instances when you've used body language that has created discomfort or when you've been made to feel uncomfortable by somebody else's body language?

According to Carline Louizia, some patients do not immediately tell providers what is ailing them. "There will be a story attached," she says.

- How can such differences in communication styles lead to frustration or misunderstanding for both patients and providers?
- How do providers generally expect to receive information?
- As Carline asks, is it up to patients to communicate in a different manner, or up to providers to learn to elicit information in a different manner?

In this video, subtitles are occasionally used when the person being interviewed is speaking English.

- Is this necessary?
- Is this appropriate?
- What are strategies for communicating with individuals who speak very good English but may have strong accents?

# Meanings of Illness *Running time: 8 minutes*

## How do meanings attributed to illness impact people's experience of illness?

**Summary:** The meanings an individual attributes to an illness – how he or she understands the causes of the illness, what he or she calls the illness, and what he or she views as appropriate prevention and treatment of that illness – vary widely and often significantly influence health behaviors. This understanding of an illness is often called an “explanatory model.”<sup>4</sup>

A person's explanatory model is influenced by a complex range of cultural and social forces. This section explores some common understandings of illness, beginning with a few reflections on general health beliefs and then focusing on cancer.

### Learning Objectives

After watching and discussing this segment, viewers will be better able to:

- explain the connection between one's understanding of illness and one's health behaviors and outcomes
- discuss the ways in which the labeling of an illness can affect experiences and behaviors related to the illness
- describe the importance of eliciting and reflecting on meanings of illness – both that of patients and of clients and providers

### Discussion Points: *Understandings of Disease Causation*

As the interviewees in this segment suggest, people believe in many different causes for cancer, including gambling, drug use, eating preservatives, and contact with someone who has cancer.

- Is it common for providers and patients to have different beliefs about disease causation?
- Why might people believe in “non-medical” theories like these?
- What are other examples of “non-medical” causes of cancer or disease in general?
- What are strategies for eliciting patients' or clients' beliefs about disease causation?
- When is it appropriate, if ever, to challenge or try to change people's beliefs?

The view that illness is caused by anti-social or sacrilegious behavior is often mentioned.

- What are possible implications of this view?
- How might it affect a person who has been diagnosed with cancer?
- How might it influence people's decisions about screening?
- What are strategies for reducing the stigma that patients with cancer, as well as other diseases, often feel?
- Can you think of personal examples of being diagnosed with – or giving a diagnosis of – something considered to be the result of “bad” behavior?

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<sup>4</sup> Kleinman, A.; Eisenberg, L.; and Good, B., Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross Cultural Research, *Annals of Internal Medicine*. 1978. 88:251-258.

The term “explanatory model” is a concept pioneered by psychiatrist and medical anthropologist Arthur Kleinman, and used by many others. The concept has been approached from different angles and been given different names by scholars in several fields (e.g., “Health Beliefs Model” and “ultimate causation”).

Kleinman and colleagues developed a method for eliciting the patient's explanatory model that includes several questions that can be asked of a patient during a clinical encounter. See the Reference section for an adaptation of Kleinman's questions, which can be photocopied and given to students to think about as they watch this section.

Sok Man Kwong comments, “Chinese people also get cancer but not as much as westerners — perhaps it’s due to the environment or maybe they did something in their previous life and now have to pay the price.”

- Does she appear to believe in a single explanatory model?
- Is it unusual for people to hold a number of different beliefs about disease causation?
- Why might people have several types of explanatory models and use various healing systems?
- Does a belief in “non-medical” causes of disease necessarily mean a person will be less likely to accept medical treatment?<sup>5</sup>

Gladys Barrientos explains, “In our countries we have a lot of beliefs. We believe in the moon, that the moon have [sic] influence, especially on ladies.” More specifically, many cultures have beliefs about appropriate health behaviors around the time a woman gives birth.

- What are other areas around which there are strong cultural beliefs (e.g. death, mental illness)?
- Why might different cultures hold distinct beliefs in these particular areas?

Some scholars believe that health care providers themselves have explanatory models of disease formed within the social and cultural environment of biomedicine.

- Do you agree?
- How would you describe the biomedical explanatory model?
- What are the key components of it?
- To what extent do you believe in this model?

## **Discussion Points: *Labeling Illness***

Many people in this segment discuss the power of the word “cancer.” Physicians themselves frequently use the abbreviation “CA” and avoid the term cancer.

- Why are people hesitant to use the word cancer?
- Is there a stigma associated with cancer?
- Is it associated with all cancers or certain kinds in particular?
- How do you use the word “cancer” in both your personal and professional life?

Sok Man Kwong comments that “doctors aren’t held accountable” when they prematurely diagnose someone with cancer.

- What do you think she means by this?
- In what ways do you agree or disagree?
- Can you think of a time when you have given a patient an incorrect impression?
- Are providers generally sensitive to a patient’s feelings about highly charged words such as “cancer?”
- If you have ever told someone that they might have a serious disease like cancer, to what extent did you consider his or her cultural background and understanding of the illness?
- To whom should providers be held accountable?

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<sup>5</sup> Although basic beliefs about causation are often resistant to change, many clinicians and researchers have found that most people are pragmatic about the treatments they will pursue. In *INFECTIONS AND INEQUALITIES* (see “Abridged List of Sources”), particularly the chapter “Immodest Claims of Causality,” Paul Farmer discusses his experience with patients in Haiti who, despite the fact that they often attribute disease to sorcery, are still very amenable to the treatments offered by the medical clinic.



## Discussion Points: Views on Prevention and Treatment

As Maude Guerrier says, the concept of early detection by a “scary” machine, like a mammography machine, is difficult for some people to understand.

- Is the concept of early detection common in most countries?
- What are strategies for explaining the concept and making such procedures less frightening?
- Can you think of personal examples of being frightened by a medical procedure or of observing someone who is? What did you do?
- *Related discussion points include Gladys Barrientos’ method of introducing women to the mammography machine before they are screened, to make them more comfortable.*

Sok Man Kwong comments, “Cancer cannot be cured, of course.”

- Why might this be a common belief among many people?
- Is treatment widely available in other countries?
- Is it available to all residents of the U.S.?
- How might this view affect people’s responses to screening or treatment recommendations?

Elly Rodriguez-Decker comments: “In the Latino Community, we’re a little bit fatalistic. If I have cancer and I let them go inside and operate and take it out, it’s going to spread.”

- What do you think she means by “fatalistic?”
- What do you think is often meant by the term “fatalistic” in literature on cross-cultural health care?
- What are some of the assumptions implicit in this term?
- For what reasons might certain people be more “fatalistic” than others?
- How do views of “God’s will” or “God’s plan for you” relate to the concept of fatalism?

Health professionals often try to accept and respect their patients or clients’ health beliefs and practices, even when the beliefs or practices are not generally accepted by western biomedicine.

- Why might providers feel compelled to do so?
- Is this done out of *respect* for these beliefs and practices and the health benefits they may, in fact, have, or is it done because providers feel they should respect people’s right to be wrong or to make “bad” decisions?
- What are the differences between these two approaches, and how do they reflect the way providers regard patients?
- Is health education a means of “correcting” beliefs and changing behavior?
- Can you think of instances when you’ve confronted health beliefs with which you did not agree? What was your attitude?

At the end of this section, Karen Wolf says, “I often find that [if] patients don’t understand...the connection between cause and treatment, that they may not follow through, and without that understanding, it really isn’t high-quality care.”

- In what ways can lack of mutual understanding undermine health outcomes?
- In addition to not “following through,” what are specific consequences of poor communication?
- *Related discussion points include problems to which a lack of understanding can lead, such as patient fear disproportionate to the diagnosis or condition, patient dissatisfaction, provider fear of malpractice suits, and provider decreased job satisfaction.*

There are some common cues that a provider and patient have different explanatory models and are not communicating well.

- What are some of them?
- If a provider suspects that he or she is not communicating effectively, what can be done?
- *Related discussion points include cues such as patient non-adherence to preventive, diagnostic, or therapeutic recommendations without a clearly expressed reason.*

# Help Seeking *Running time: 9 minutes*

## What do people do to promote health or treat illness – and why?

**Summary:** A person's decisions about where to go for help and how to prevent or treat illness are affected by many factors, including his or her culture. This section explores some of the frustrations and barriers that discourage people in this country from seeking care from the formal health care system. It also introduces viewers to some of the other healing systems and healers from whom patients may seek care.

### Learning Objectives

After watching and discussing this segment, viewers will be better able to:

- discuss common frustrations with the U.S. health care system
- explain the ways in which medicine is its own distinct culture in the U.S.
- describe the range of healing systems that are used in the U.S. and the degree to which several different systems are often used simultaneously
- implement strategies for eliciting information about people's various help-seeking behaviors

### Discussion Points: *Frustrations with U.S. health care*

At the beginning of this segment, Ken Fox refers to the health care encounter as “an act that's constructed by the culture of the patient, but also the culture of the provider and the culture of the institution the provider delivers his care within.”

- Do individual providers and health care institutions have their own cultures?
- How would you describe the biomedical culture?
- What are some aspects of the culture of the institution in which you work that might affect patient care?

Gladys Barrientos explains, “People from my community expect from a doctor to provide good medicine and to be cured. Most of our people from my community has [sic] been complaining, taking a day off from work, going to the emergency room and being prescribed with a Tylenol.”

- What are other common expectations?
- How does a patient arrive at these expectations?
- How do patients' previous health-related experiences – within or outside the U.S. – affect these expectations?
- What are your own expectations when you enter the health care system, and what are they based on?

Various factors affect a patient's experience and satisfaction with the health care system.

- What are some of the things that may lead to a dissatisfying experience (e.g. long waits, lack of personal attention, use of invasive procedures)?
- Do these things affect all patients equally?
- What are some of the factors that often lead to a satisfying experience?
- What are some practical methods of improving the system to better satisfy patients?

Sok Man Kwong describes the fear and discomfort she feels when her blood is drawn. “They sampled so much blood from me, like three full containers,” she says.

- Why might this be considered necessary?
- When, if ever, is it inappropriate?
- How might a patient's culture impact his or her reaction to this procedure?

- Is drawing blood common in other countries or other healing systems?
- What are other instances when providers may put their clinical priorities ahead of patients' comfort or preferences?
- Can you think of instances when, as a patient, you felt that your own preferences were overlooked or when, as a provider, you may have overlooked a patient's preferences?
- How might you treat family members or friends differently if they were your patients or clients?

## Discussion Points: *Other Sources of Care*

In the video's introduction it is noted that "An estimated 70% to 90% of all self-recognized episodes of sickness are managed outside of the formal health care system."<sup>6</sup> In other words, most people who become sick never appeal to doctors or nurses for help.

- What does this suggest?
- Are people not seeking help at all, or are they seeking help from other caregivers?
- What are some examples of healers or healing systems that are not part of the biomedical system?
- Why might these different caregivers and systems be preferable to some people?

Sok Man Kwong says that after taking her daughter to an American doctor for her asthma, she was not cured. But after switching to a Chinese doctor, "she was cured within six months."

- What is your reaction to her story?
- Based on the medical understanding of asthma, could this be true?
- Is it possible that another health system could "cure" asthma?
- What does "cure" mean?
- Does it necessarily mean the same thing to health care providers and patients?

Sok Man's story might be better understood in light of the research of social scientists like Arthur Kleinman and Leon Eisenberg. They and their colleagues suggest that illness and disease are two distinct concepts: illness is the patient's experience of disease or discomfort, and disease is the doctor's understanding of physical changes in the body.<sup>7</sup> Eisenberg also argues that physicians' training ignores the concept of illness and its treatment, while traditional practitioners are more likely to treat the human experience of sickness.

- What do you think of this distinction?
- How might it relate to Sok Man's story?
- Could Sok Man's daughter have been cured of her illness while continuing to have the disease?
- Does physician training overlook the concept of illness, as Eisenberg suggests?
- How might eliciting information about a person's understanding of illness help providers deliver care and improve patient satisfaction?

Carline Louizia says, "Prevention in a sense as it's practiced here is not the same as we do in Haiti or in the Haitian community."

- Is preventive medicine practiced in most countries?
- In countries or communities where it is practiced, what may it involve?
- In addition to drinking tea, as Louizia mentions, what are other common preventive behaviors?
- Do these behaviors differ from those recommended by U.S. health care providers?

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<sup>6</sup> Kleinman, A.; Eisenberg, L.; and Good, B., Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research, *Annals of Internal Medicine* 1978; 88: 251-258.

<sup>7</sup> *Ibid.*

Karen Wolf describes the case of a Chinese woman with hypertension who divides her time between the U.S. and China and alternates between American and Chinese treatments. Karen says, "It was a challenge for me not to pass judgment but rather to accept and understand how important it was for her to try to integrate [the two]."

- In what ways are people's help-seeking behaviors often complex and dynamic?
- What health systems/healers do you use when you are ill?
- Have you ever used two systems at once? (e.g. have you taken herbal remedies and prescription drugs simultaneously?)
- How do providers tend to communicate judgment or disapproval?
- Have you ever conveyed judgment or felt judged by a health care provider? What was the experience like?

# Social and Historical Context *Running time: 13 minutes*

## How do social context and personal history impact health behaviors?

**Summary:** A person's position within a complex web of social factors – a web that includes socioeconomic status, race, ethnicity, culture, and other aspects of one's personal history – affects health status significantly. This segment explores the way in which an individual's social and historical context can affect health beliefs and behaviors. It also investigates issues of particular concern to newcomer, immigrant, and refugee populations.

### Learning Objectives

After watching and discussing this segment, viewers will be better able to:

- describe the overlap of socioeconomic status, race, ethnicity, and culture, and the importance of viewing them as separate elements
- explain the importance of trust between providers and patients or clients and the implications of mistrust
- discuss key health concerns and barriers to care among newcomer, immigrant, and refugee populations in the United States

### Discussion Points: *Social and Economic Inequalities*

As Ken Fox's story of the boy with AIDS demonstrates, it is often hard to untangle issues of culture, race, ethnicity, and socioeconomic status.

- In this case, are these factors interrelated?
- What were the possible dangers of confusing them?
- Can you think of times when you may have confused these factors? What happened?

Many people in this section offer examples of socioeconomic barriers to health care.

- What are some of them? (e.g. inability to pay for transportation, childcare, or medicine; difficulties related to employment)<sup>8</sup>
- Even if a person is able to get to a doctor, how might socioeconomic issues impact his or her ability to follow recommendations?
- *Related discussion points include: the concept of "patient agency,"<sup>9</sup> the notion that knowledge and intent are not always enough for people to change behaviors, and the idea that a sense of control over one's life and environment is essential to do so.<sup>10</sup>*

Carline Louizia says that many people consider "free care" – or government-funded health care – to be inferior to other health care.

- Why might this be a common concern?
- Are these concerns warranted?
- In addition to breast reconstruction, which is discussed in this segment, are there other benefits that are not covered by most public programs?
- How, if at all, does a patient's health insurance status affect the care a provider delivers?
- Would you be willing to accept "free care" for yourself or your family?

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<sup>8</sup> Note the difference between a wage worker and a salary earner. Many health professionals, accustomed to earning salaries, may not realize that an hour sitting in the waiting room means an hour not getting paid.

<sup>9</sup> The notion of "patient agency" is prominent in Paul Farmer's work. See especially the chapter "Vitality of Practice" in *INFECTIONS AND INEQUALITIES* (see "Abridged List of Sources").

<sup>10</sup> Ogur, B., "Community and Cultural Diversity in Medical practice," lecture for Primary Care Internal Medicine Principles and Practice, November 9, 2000.

As Hope White says, “There’s a definite historical link to black people not trusting the health system.”

- What is the Tuskegee study to which she refers?<sup>11</sup>
- What are other examples of incidents that have made certain populations mistrust the health care system?
- What are strategies – both on the policy and individual levels – to rebuild trust with individuals and communities?

At the end of this section, Ken Fox offers statistics reflecting the health disparities that exist in this country. In particular, he points out that “a black man in Harlem has a lower life expectancy than a man in the Third World, in Bangladesh” and that “a boy in Harlem of 15 has only a 30% chance of surviving to age 65.”

- What is your reaction to these statistics?
- What are strategies for improving basic vital statistics in the United States, particularly among traditionally under-served populations?
- As Ken says, how do we achieve an outcome like this in the wealthiest nation on the face of the earth?

## **Discussion Points:** *Newcomer, Immigrant, and Refugee Health Issues*

The heading for this subsection of the video is “Newcomer, Immigrant, and Refugee Health Issues.”

- What is the difference between these three categories?
- How might these groups – or members of each group – differ with regard to their social and historical contexts?
- How might these differences come to bear on health?

Samuth Koam, Munty Pot, and Mojdeh Rohani discuss the issue of trust and mistrust and its effect on help-seeking behaviors and provider-patient interactions.

- What are some of the implications of mistrust with respect to health and health care?
- What are strategies for building trust with people and communities who may be apprehensive about U.S. health care and health care providers?
- In what way is this mistrust similar to or different from the mistrust Hope White describes among African Americans?

In this section, various reasons are offered as to why people new to this country may not readily seek health care, particularly preventive care.

- How might immigration status affect help-seeking behaviors?
- How might past experiences in a violent country?
- How might a personal history of political or social persecution?
- How might a history of physical or sexual abuse?
- Why might prevention be a particularly low priority for many people new to this country?
- *Related discussion points include the effect of past experiences on a person’s perception of health risks and priorities. For instance, consider Samuth Koam’s suggestion that in a country where guns are the major killer, cigarettes may seem quite harmless.*

Given the issues addressed in this segment, it is important for providers to understand some basic aspects of a patient’s personal history in order to provide high-quality care.

- How can this information be elicited in a sensitive manner?
- In addition to asking the patient or client, what are ways to learn about his or her cultural background?
- How might a multidisciplinary and multicultural team approach help improve understanding and trust between providers and patients?

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<sup>11</sup> A good source for more information on Tuskegee is James Howard Jones’ *BAD BLOOD — THE TUSKEGEE SYPHILIS EXPERIMENT*, Simon and Schuster Trade, 1992.

# Core Cultural Issues

Running time: 13 minutes

## How do values regarding authority, gender, physical contact, decision making, and religion affect health?

**Summary:** There are certain areas where the potential for misunderstanding between people from different cultural backgrounds is particularly great. This section explores some important areas in which cultures differ and the effects that these differences can have on provider-patient/client interactions and health.

### Learning Objectives

After watching and discussing this segment, viewers will be better able to:

- describe some of the ways in which the key areas of authority, gender and physical contact, decision making, and religion and spirituality impact health and the delivery of health care
- recognize cues indicating that one or more of these key areas is affecting the health care encounter
- implement strategies for delivering high-quality cross-cultural care

### Discussion Points: *Authority*

Atika Kouhail and Isabel Pintofranco both discuss the issue of provider authority and suggest that many people would rather receive a single recommendation from their provider rather than be given several options from which to choose.

- How does medical education generally teach providers to address this issue?
- Should the provider necessarily present information to patients in the way that makes them most comfortable?
- What are strategies for providers to understand their patients' preferences?
- Does fear of looking "incompetent," as one interviewee mentions, influence providers' behavior?

Elly Rodriquez-Decker explains, "Most Latino women don't feel comfortable talking to a doctor or questioning the doctor, the physician, or the primary care nurse, especially because physicians, health care providers, are held to a very high standard, next to God."

- Is reluctance to challenge providers an attribute specific to Latino women?
- What factors may make some people more or less reluctant to question or challenge providers? (e.g. consider Rodriquez-Decker's point that educated women are more confident in this respect)
- How can a patient's willingness or unwillingness to question providers affect the quality of care delivered?
- How can providers make patients feel more comfortable asking questions or expressing concerns?
- Do you think most providers want to be questioned?
- Has a patient or client ever challenged you? What did it feel like? How did you respond?

Karen Wolf comments that "In health care we have this funny term we call 'noncompliance' and the assumption behind noncompliance is that it is up to the patient to comply with a plan that the health care provider has developed."

- What is your opinion?
- How would you define "compliance"?<sup>12</sup>
- After hearing these definitions, how do you feel about using the term?
- What power dynamics are implicit in this term?

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<sup>12</sup> According to MERRIAM WEBSTER'S COLLEGIATE DICTIONARY, compliance is "the act or process of complying to a desire, demand, or proposal or to coercion." THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE defines it as "a disposition or tendency to yield to the will of others."

When a patient or client does not follow a health care provider's recommendation, this may be due in part to the fact that he or she is following the advice of a different type of caregiver.

- What are other health authorities or common sources of health information and advice?
- Do most providers recognize the impact of these other authorities?
- Who do most health care providers look to as authorities on health information?
- What is likely to happen when patients and providers have different concepts of authority?

In this segment, Ric Blake, who is a non-Hispanic white man from Appalachia, makes a general comment about the Latino and Appalachian communities. He says, "The Latino community, the Appalachian community are focused on home, family, neighborhood..."

- On what basis is someone entitled to speak about a particular culture?
- How do you feel about him talking about the Latino community?
- How do you feel about him talking about the Appalachian community?
- Does it make a difference to know that his job involves working closely with Latinos?
- What community or communities would you personally feel comfortable talking about?

## **Discussion Points:** *Gender and Physical Contact*

Elly Rodriguez-Decker and Hope White both mention reasons why some men are reluctant to seek prostate cancer screening.

- What are some of the reasons?
- Are these specific to certain cultural groups or are they more universal?
- What are strategies to address these concerns and encourage men to get screened?

In this segment, several people talk about the issue of physical contact between patients and providers.

- What factors may make some people less comfortable when being closely examined by a provider?
- In what ways is the U.S. health care system sensitive or insensitive to beliefs about physical contact?
- Do you feel differently about physical contact when you are visiting a health care provider as a patient rather than seeing patients as a health care professional?

Some cultures and individuals create what social scientists have called a "moral geography" of the body.<sup>13</sup> For example, in certain cultures, it is common for women to show their breasts in public, whereas in other cultures it is expected that women conceal their breasts, along with other body parts.

- What parts of the body are considered "private" in some cultures?
- What factors inform an individual or culture's "moral geography" of the body?
- What parts of the body do most cancer screening tests involve?<sup>14</sup>

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<sup>13</sup> O'Connor, B., HEALING TRADITIONS: ALTERNATIVE MEDICINE AND THE HEALTH PROFESSIONS (STUDIES IN HEALTH, ILLNESS, AND CAREGIVING, University of Pennsylvania Press, 1995.

<sup>14</sup> The culturally taboo or sensitive parts of the body are those most targeted in violence. They are also targeted in cancer screening. (Bonnie O'Connor, telephone conversation, March, 2001)



## Discussion Points: *Decision Making*

Isabel Pintofranco describes the case of a patient with lung cancer whose wife does not want her husband to be told of his condition. They ultimately decided to ask the patient what he wanted to know – “the whole thing” versus “just what he needed to do” – and he opted for the latter.

- What do you think of the providers’ approach to this patient and his wife?
- What were other possible approaches to the situation?
- What responsibility, if any, do providers have to follow the wishes of family members?

Research has shown that telling patients the details of their medical diagnoses and prognoses – often called “truth telling” – is sometimes viewed as dangerous or disrespectful to the patient. Carline Louizia’s description of how her family has dealt with her father’s diagnosis of prostate cancer raises many related questions.

- Why is her family reluctant to tell their father about his diagnosis?
- What effect might his age have on their decision?
- Do you think theirs is a positive coping mechanism?
- Were you her father’s provider, how might you feel about the family’s approach?

Isabel Pintofranco describes the case of a young man with melanoma whose wife and mother were actively involved in his ultimately fatal decision not to receive treatment.

- Would it have been appropriate for the provider to intervene and discourage the family from being involved in this patient’s decision?
- What, if anything, might the provider have done to convince the man to get treatment?
- What role does the concept of autonomy and individual decision making play in western medical-ethical literature? (e.g. in literature on advance directives and informed consent).
- Do all cultures value individual autonomy and individual well-being in the same way?
- What do some cultures value above the individual?

Most of the comments made regarding decision making in some way involve the concept of “informed consent.”

- What do you think of this terminology?
- Did you know that the term is shortened from “informed consent or refusal?”
- Would most providers be comfortable calling it “informed refusal?”
- Would you be comfortable using the term “informed refusal?”

## Discussion Points: *Religion and Spirituality*

This section demonstrates some of the ways in which people's religious or spiritual convictions can affect their health beliefs and practices.

- In what ways can religious or spiritual faith be seen as a barrier to health?
- When, if ever, is it appropriate to challenge a patient whose faith leads him or her to avoid receiving care?
- In what ways can a person's faith help promote his or her health (e.g. the social support provided by many religious organizations, or prohibitions against smoking or drinking)?
- Is it appropriate for providers to appeal to a patient's religious views when promoting behaviors like smoking cessation?
- How do various religions or spiritual faiths differ with respect to views on seeking medical care (e.g. the Bahai and Christian Science religions)?

Expressing a view she often hears in her community, Halima Ali says, "If I go to the doctor for health issue, the medicine I will get, it will kind of help, but whoever can make me recover, it's only the Allah. Most of the people when they read the Koran, they personally get much better."

- What is your reaction to this view?
- In addition to reading the Koran, what are other examples of faith-based healing practices (e.g. prayer, consultation with religious leaders)?
- Can a patient have faith in both Allah, as in this case, and western medicine?

Samuth Koam, who was once a monk, describes the many issues about which people would come to him for help.

- To what extent does the U.S. health care system acknowledge the important role of religious leaders in terms of health and healing?
- At what stage of the caregiving process are religious figures usually brought into the health care system?
- What are some strategies for incorporating religious leaders into the process of caregiving?
- Are most providers open to collaboration with non-medical experts?

# Building Bridges

Running time: 4 minutes

## How can we work together to provide high-quality care to diverse individuals and communities?

**Summary:** *Community Voices* explores many of the areas in which culture can affect our ability to connect with patients, clients, and communities. The resulting connection, or lack thereof, can have dramatic implications for the health of those we serve and for our job satisfaction.

In this final segment, people reflect on the importance of building bridges, whether they are with individual patients or clients, or with larger communities. The segment also highlights the challenges and rewards of cross-cultural care.

### Learning Objectives

After watching and discussing this segment, viewers will be better able to:

- describe the importance of building trusting and respectful relationships with individual patients or clients and communities
- develop strategies for working with individuals and within communities to foster such relationships

### Discussion Points

At the beginning of this section, Ken Fox explains, “What we’re trying to achieve is the very best outcome that is possible, the highest possible attainable standard of health that can be achieved for the person sitting before us, and for the population that the person belongs to.”

- As he asks, how are you going to achieve that?
- What are some of the general approaches discussed in this video?
- What are some of the more specific strategies described in the video?

Munty Pot, Ric Blake, and Carline Louizia describe the importance of working with communities and community members to promote health.

- How do such partnerships help to promote health and improve the quality of care delivered?
- What are effective and realistic ways for providers to become involved in the communities they serve?
- Who are the gatekeepers in most communities?
- Who are the gatekeepers in the communities where you live and work?
- What are some of the community-based organizations through which health outreach work can be done?

Rather than assume anything, Isabel Pintofranco suggests that health care providers simply ask foreign-born patients or clients, “How do you do this in your country?”

- What are the possible benefits and risks of this approach?
- Would most providers be willing to ask this question?
- Would you be willing to? Why or why not?
- How might a team approach help providers attain this information?

Samuth Koam says that in some cases, patients feel that “[Providers] only take the data. They are not even concerned or care about what’s inside me.” Similarly, Hope White explains, “A lot of women feel that they’re just looking at me as a body or a body part...they’re not looking at me as a person because they’re not...even inquiring to me about who I am.”

- What is your reaction to these comments?
- Are patients who feel this way being overly sensitive?
- Do you think that this view of health care providers is universal or more common among certain racial, ethnic, or cultural groups?
- Does medical education teach providers to care about “what’s inside” the patient?
- What are some of the factors that keep providers from getting to know patients better? (e.g. time, reimbursements, professional etiquette)

Karen Wolf concludes this section by saying, “That’s what works best for our patients – to view ourselves as facilitators for health rather than directors of health.”

- What does it mean to be a “facilitator of health” rather than a “director of health”?
- What are some of the ways in which this difference is actually demonstrated?
- Is this the ideal role of the health care provider?
- Does this answer depend on whether you’re answering as a professional or as a patient?
- Have this video and the related discussion helped you in your role as a “facilitator of health”? If so, how?

# References

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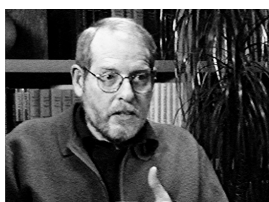
## People Featured in the Video



**Halima Ali**  
Counselor and  
Victim Advocate



**Gladys Barrientos**  
Community Health  
Worker



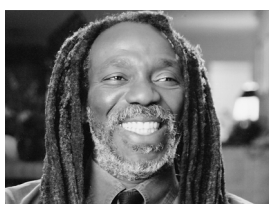
**Ric Blake**  
Community Organizer  
and Thyroid Cancer  
Survivor Advocate



**Kenneth Fox**  
Pediatrician and  
Medical Anthropologist



**Maude Guerrier**  
Community Health  
Worker



**Idi Jawarakim**  
Medical Interpreter



**Samuth Koam**  
Community Health  
Educator



**Atika Kouhail**  
Medical Interpreter



**Sok Man Kwong**  
Patient



**Carline Louizia**  
Physician and Community  
Health Educator



**Isabel Pintofranco**  
Medical Interpreter



**Munty Pot**  
Community Health  
Educator



**Elly Rodriguez-Decker**  
Breast & Cervical Cancer  
Health Program Coordinator



**Mojdeh Rohani**  
Clinical Social  
Worker



**Hope White**  
Breast Health  
Program Manager



**Karen Ann Wolf**  
Sociologist and  
Nurse Practitioner

## Statistics from the Video's Introduction<sup>16</sup>

**Approximately 14% of the U.S. population speaks a language other than English at home.**

- U.S. Census Bureau, 1990 Census of the Population, CPHL-133. <http://www.census.gov/population/socdemo/language/table5.txt>. Accessed January 8, 2001.

**25% of all deaths in the U.S. are the result of cancer.**

- American Cancer Society. Cancer Facts and Figures 2000. (Atlanta, GA: American Cancer Society National Home Office, 2000), 2.

**At least 50% of cancers are preventable.**

- Colditz, G.A.; DeJong, D.; Hunter, D.J.; Trichopolous, D.; Willett, W.C., eds. Harvard Report on Cancer Prevention. Volume 1. Causes of Human Cancer. Cancer Causes and Control 1997, 7 (Suppl): 1-59.

**An estimated 70% to 90% of all self-recognized episodes of sickness are managed outside of the formal health care system.**

- Kleinman, A.; Eisenberg, L.; Good, B., Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. Annals of Internal Medicine, 1978, 88: 251-258.

**The foreign-born population of the United States is over 28 million, the largest in U.S. history.**

- U.S. Census Bureau, The Foreign-Born Population in the United States: Population Characteristics. March 2000. <http://www.census.gov/prod/2000pubs/p20-534.pdf> Accessed April 26, 2001.
- U.S. Census Bureau, Census Brief: Coming to America: A Profile of the Nation's Foreign-Born. <http://www.census.gov/prod/2000pubs/cenbr002.pdf>. Accessed April 26, 2001.

**At least 50% of African Americans, Hispanics, and American Indians and 20% of non-Hispanic whites are poor or near poor.**

- The Henry J. Kaiser Family Foundation, Key Facts: Race, Ethnicity & Medical Care. October 1999. Source: March 1998 Current Population Survey.

**Prostate cancer kills over 31,000 men in this country every year – the incidence among African American men is the highest known rate in the world.**

- American Cancer Society. Cancer Facts and Figures 2000. (Atlanta, GA: American Cancer Society National Home Office, 2000), 14.
- Centers for Disease Control and Prevention, Prostate Cancer: Can We Reduce Deaths and Preserve Quality of Life? 2000. <http://www.cdc.gov/cancer/prostate/prostate.htm> Accessed April 26, 2001.

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<sup>16</sup> The statistics provided in the video include terminology that may not be preferred usage among all viewers. We have generally used the terminology that most often appears in the research from which our statistics are derived but, in some cases, have changed it to be internally consistent.

**Minority women are nearly twice as likely as non-Hispanic white women to report not knowing at what age to start getting mammograms.**

- National Cancer Institute, Office of Cancer Communications. Knowledge, Attitudes, and Behavior of Women Ages 65 and Older on Mammography Screening and Medicare: Results of an Omnibus Study. Bethesda (MD); National Cancer Institute; July Report No.: POS-T162.

## **Guide to Eliciting Patient or Client Information**

These questions, taken from the article by Dr. Arthur Kleinman, *et al*, entitled Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research,<sup>17</sup> are designed to help explore the meanings of illness. The questions can be modified as needed. (They can be oriented to disease prevention rather than treatment, for example).

- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is your sickness? Will it have a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

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<sup>17</sup> Kleinman, A.; Eisenberg, L.; Good, B., Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. *Annals of Internal Medicine* 1978; 88: 251-258.

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## **Abridged List of Sources: Web Sites**

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**Closing the Gap:** [www.closing-the-gap.com](http://www.closing-the-gap.com)

**Cross-Cultural Health Care Program (CCHCP):** [www.xculture.org](http://www.xculture.org)

**Diversity Rx:** [www.diversityrx.org](http://www.diversityrx.org)

**EthnoMed:** <http://healthlinks.washington.edu/clinical/ethnomed>

**Health Resources and Services Administration:** [www.bphc.hrsa.gov](http://www.bphc.hrsa.gov)

**Intercultural Cancer Council:** [www.iccnetwork.org](http://www.iccnetwork.org)

**Intercultural Press:** [www.interculturalpress.com](http://www.interculturalpress.com)

**National Cancer Institute:** <http://crchd.nci.nih.gov>

**National Health Law Program:** [www.healthlaw.org/immigrant.shtml](http://www.healthlaw.org/immigrant.shtml)

**The Provider's Guide to Quality and Culture:** <http://erc.msh.org>

**US Department of Health and Human Services:** [www.raceandhealth.hhs.gov](http://www.raceandhealth.hhs.gov)  
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**Through Cancer**

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